HEALTH CARE REFORM

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

VOLUME IV

Issues Relating to Medical Malpractice

MAY 20, 1993

Issues Relating to Administrative Simplification

MAY 25, 1993

State Regulation of Private Health Insurance

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ISSUES RELATING TO MEDICAL MALPRACTICE

THURSDAY, MAY 20, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:09 a.m., in room 1100 Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
FRIDAY, MAY 14, 1993

PRESS RELEASE #11
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
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THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING
ON
HEALTH CARE REFORM:
ISSUES RELATING TO MEDICAL MALPRACTICE

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on issues relating to medical malpractice on Thursday, May 20, 1993, beginning at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.

In announcing the hearing, Chairman Stark said: "The current malpractice system costs too much, leaves many injured patients with no compensation, and fails to provide effective incentives to reduce the number of medical injuries."

Oral testimony will be heard from **invited witnesses only**. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND:

National health expenditures in the United States have escalated to more than $900 billion this year. The precise extent to which medical malpractice contributes to the rising health care bill is unknown.

According to the General Accounting Office (GAO), physicians paid $5.9 billion and hospitals paid $1.3 billion in premiums for malpractice insurance in 1990. Premiums vary widely depending on the specialty involved and the physician's geographic location. Some physicians argue that the fear of litigation has caused them to do more tests and procedures, a practice known as defensive medicine. The potential savings associated with defensive medicine are nearly impossible to estimate accurately.

The existence of an injury resulting from negligent medical care does not necessarily result in a claim being filed. According to the Harvard Medical Practice study, eight times as many patients suffered an injury from negligence as filed a malpractice claim. Further, about sixteen times as many patients suffered an injury from negligence as received compensation from the tort liability system.

Malpractice suits are generally resolved under State tort laws. In the past 15 years, every State has enacted some type of reform in an effort to limit the increasing costs of malpractice. A recent study showed that caps on awards, reductions in the statute of limitations, and offset to awards to reflect payments from collateral sources have some impact on the growth in malpractice awards.

(MORE)

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DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Thursday, June 3, 1993, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

* * * * *

Chairman STARK. Good morning. Today the subcommittee continues its series of hearings on health care reform. These hearings are intended to lay a foundation, a foundation needed to enable the President to enact comprehensive health care reform.

National health expenditures in the United States have escalated to more than $900 billion this year. The precise extent to which medical malpractice has contributed to the rising health care bill is unknown.

The regulation of malpractice has traditionally been left to the States. In the past 15 years, every State has enacted some type of reform in an effort to limit the increasing costs of malpractice or malpractice insurance. Yet, there is still no evidence that these tort reforms have had any effect on the methods in controlling health care costs.

During the past decade, the issue of medical malpractice has been defined largely in terms of the cost and availability of malpractice insurance. According to the General Accounting Office, physicians paid almost $6 billion and hospitals paid $1.3 billion in premiums for malpractice insurance in 1992. Malpractice premiums account for less than 1 percent of national health care expenditures.

An issue which has received significant attention lately is the cost associated with "defensive medicine," medicine generally defined as medical practice induced by the threat of liability.

Even with some changes in the malpractice system, defensive medicine would probably still be provided for reasons other than concerns about malpractice. Those reasons might include, but are not limited to, advances in medical technology, payment incentives that encourage providers to offer more services, and changes in expectations about appropriate medical care. In addition, most physicians want to provide their patients with the best possible medical care and hopefully would do so even without the threat of lawsuits.

The system for compensating individuals injured through medical negligence is neither efficient nor equitable to those most directly affected by the malpractice, the injured patients. A recent Harvard study of medical malpractice indicates that patients who suffered an injury from negligence outnumbered those who filed a malpractice claim by almost 8 to 1. Further, about 16 times as many patients suffered an injury from negligence as received compensation from the tort liability system.

I think it is important to note here that getting involved in the medical delivery system is a risky business. It is as risky as driving on the freeway. Simply by the luck of the draw, you can get hurt and need additional care. That is costly, and not necessarily the kind of malpractice that one would associate with negligence, despite the number of patients who suffer from injury.

Here is another problem. Despite the number of patients who suffer an injury from negligence, few of the Nation's 600,000 practicing physicians have had any disciplinary measures taken against them. For example, in 1991, State medical boards took only 2,800 disciplinary actions against physicians and they ranged from mere reprimands to a paltry few license revocations.

So the committee, I suspect, will be well-advised to see that injuries caused by negligence are indeed fairly compensated. Mal-

practice reform and quality of medical care go hand in hand. Any malpractice relief must be accompanied by a physician community doing a better job in disciplining its membership, and insuring quality.

This hearing provides us with an opportunity to evaluate issues relating to the medical malpractice system. Before proceeding, I would like to recognize the distinguished ranking member, Mr. Thomas, for his opening statement.

Mr. THOMAS. Thank you, Mr. Chairman.

I don't have a formal written statement, but I would like to say that as we begin some of the more specific hearings on parts of any comprehensive reform in the health care system, that while Congress has seldom held hearings and has not acted, the States have been very active in making changes. I would ask the gentleman from Texas if he would like a cracker.

Mr. ANDREWS. I appreciate if you would yield. Not only would I like a cracker, I would like to ask my friend from California if he would like a pin.

Mr. THOMAS. I would love a pin.

Mr. ANDREWS. It is from the South.

Mr. THOMAS. Well, I am from southern California.

Mr. ANDREWS. I have one for Chairman Stark, too, as a matter of fact.

Chairman STARK. Good. I had one being prepared, "Bubbas for Health Reform," but I didn't bring it.

Mr. ANDREWS. I would rather be called Bubba than a Cracker.

Chairman STARK. That makes sense.

Mr. THOMAS. Reclaiming my time, Mr. Chairman, I am concerned that we have not done enough modeling and examining of options that have begun to be presented to us by the States. I know we will shortly hear from GAO on a kind of a general review and, frankly, I am not as pleased with the structure as I would like and will be asking some questions.

All of us know that to solve this one particular problem in the health care arena is going to require changes on the part of doctors, lawyers, patients, and insurers. In the last Congress, Republicans offered a medical malpractice resolution in what was known as Action Now in this Congress has been reintroduced as H.R. 101.

My friend and colleague, Alex McMillan, on the Energy and Commerce Committee has been interested in this area and he has introduced a perfected piece of legislation. H.R. 3857, which he believes offers answers to some of the questions that the chairman posed on this particular subcommittee and committee, our friend Nancy Johnson of Connecticut in H.R. 1625 has offered a slightly different structure. Nevertheless, a worked out specific plan which I think has great merit.

I believe one of my charges is to also offer alternatives and to that end, Mr. Chairman, I am preparing a piece of legislation which will generally reflect almost in its entirety the malpractice reforms recently completely enacted in California after more than almost a decade and a half of getting the legal structure worked out.

And so I am looking forward to any offerings on the part of the chairman or other Democrats who feel that there needs to be

changes in this area because, Mr. Chairman, we can hold hearings until the cows come home and soak up what is going on in Maine and in the Harvard studies and in Virginia and all of the other areas that are beginning to play with the issue, but it seems to me that there are some fundamentals that probably need to be attacked at the Federal level, not the least of which is a general examination of the whole area of antitrust which I believe inhibits the States from moving forward in as comprehensive a way as they might want to in solving the problem.

And so I look forward to this hearing and perhaps subsequent hearings as more specific proposals come on the table from your party and your administration and we can begin in a direct comparison, provision by provision, to determine through expert testimony which ones might work better, why certain ones aren't as good as others and then focus on what we have out there as a body of evidence which would give us justification for moving in a particular direction. Because as far as I am concerned, something like malpractice is too important to wait for the overall comprehensive reform which may or may not be coming to us this year.

I think specific portions of health care reform can be moved forward if necessary and I believe this is one of them and I thank the chairman.

Chairman STARK. Any other statements?

Mr. GRANDY. Mr. Chairman?

Chairman STARK. Mr. Grandy.

Mr. GRANDY. Thank you, Mr. Chairman.

I want to, first of all, thank you for conducting a hearing which I notice is titled "Issues Relating to Medical Malpractice." And I think that is apt because, clearly, issues that are not technically under malpractice or tort reform such as antitrust reform and outcomes research and the practice guidelines that may derive from them I think are all part of this.

I have told constituents and particularly advocates of malpractice reform that the end of waste, fraud, and abuse does not lie exclusively down this path and I think it is important at the outset to say that this is only one component of health care reform, albeit an important one.

I do think, though, that part and parcel of that is as Mr. Thomas alluded to in his remarks at least questions that might be placed on whether or not antitrust reform which will supposedly allow a greater option for physicians to police themselves will actually result in coming forward with a greater awareness of negligent providers, and that is a question I hope to put before the witnesses today because that has not been significantly answered.

It is my understanding that the issue will not even be addressed in the GAO study, but I think we have to be mindful that some of the mechanisms that have been used at the State level, such as peer review, at this point I would have to say are probably not insufficient to weed out some of the problems that we have within the system.

So I appreciate the opportunity to discuss a range of issues, as you say, relating to medical malpractice and will be trying to concentrate my questions on just how effective a tool antitrust reform

would be in trying to get to the higher quality and broader base of medical practice.

Thank you, Mr. Chairman.

Chairman STARK. Are there other statements? The Chair notes that our leading Member, we have one attorney with us, well I guess—two attorneys. And the Chair would like, just for the record——

Mr. McCRERY. Mr. Chairman, I try to keep that quiet.

Chairman STARK. It is OK. In a hearing a couple of years ago, a witness defined for us the difference between negligent malpractice and accidental malpractice, which I think the committee might find interesting as we hear this discussion today.

What they basically suggested was that should one of us go into an emergency room and be asked all the questions that a doctor would ask after an accident, including "Are you allergic to anything?" And you answered "to the best of my knowledge I am not allergic to anything." The doctor proceeded to give you a shot of penicillin. The reaction caused you to go into shock and spend an extra day in the hospital. That, in fact, is malpractice, but it isn't negligent. It is just one of those accidents.

On the other hand, had we gone into that same emergency room wearing one of those little medallions that say, "I am allergic to penicillin," and told the person receiving us that we were allergic, yet they proceeded not to tell anybody and they still jabbed you with the penicillin. After you had the same reaction, that would be negligent malpractice.

I would defer to the attorneys to see if that in general makes sense, because I think we will hear those issues raised today about the differences between negligent and accidental malpractice. There seems to be a difference and I just submit that to the Members as something to keep in mind.

I am sure that the attorneys understand all this, but I found that a rather interesting anecdote to keep track of the difference.

Mr. THOMAS. Would the chairman yield?

Chairman STARK. Mr. Thomas.

Mr. THOMAS. Would you feel as comfortable that there is a black and white line between those examples if you did not run a test that may or may not be customary in terms of examples, and in a courtroom when the attorney brings forth expert witnesses indicating that most people know it is customary practice——

Chairman STARK. If the gentleman would yield, I don't make any question of that as a definition. I say again it is an anecdote which describes on the one hand a case that might be considered negligent and on the other a case which might be considered an "accident." I am sure that these same questions are what lawsuits are made out of.

And I just——

Mr. THOMAS. My inclination in bringing that up is to indicate that I believe the question of negligence probably pushes all the way over to the bracelet and that everything on the other side of the bracelet is subject to a court, the judge, attorneys, jury and the ability of all to perceive what is just and fair.

Chairman STARK. We will begin with testimony from the General Accounting Office represented by Lawrence H. Thompson, the As-

sistant Comptroller General, Human Resources Division. He is accompanied by Susan Kladiva, the Assistant Director for Health Financing Issues; and Joseph A. Petko, who is a senior evaluator.

As with all of our witnesses today, the entire prepared statements will be included in the record and we would ask you to proceed to summarize or expand on your written testimony in whatever manner you are comfortable.

STATEMENT OF LAWRENCE H. THOMPSON, ASSISTANT COMPTROLLER GENERAL, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY SUSAN D. KLADIVA, ASSISTANT DIRECTOR, HEALTH FINANCING ISSUES; AND JOSEPH A. PETKO, SENIOR EVALUATOR, HUMAN RESOURCES DIVISION

Mr. THOMPSON. Thank you, Mr. Chairman. We appreciate your invitation to come here today to discuss the problems created by medical malpractice and various efforts under way to deal with the malpractice problem. We do not know the precise extent to which medical malpractice has contributed to the Nation's spiraling health care bill. It may not be the most important factor. But it does involve billions of dollars and it represents a major concern for our health care system.

Over the last 20 years, the malpractice issue has been identified most frequently in terms of the cost and availability of insurance. For example, total spending for medical malpractice insurance by physicians increased from $2 billion in 1983, to almost $6 billion in 1990, and among hospitals has increased from about $800 million in 1983 to we think over $2 billion in 1990.

Cost increases have slowed somewhat in the last few years. And, in part, due to the creation of new physician- and hospital-owned insurance companies, insurance is now available to most providers. This does not mean that malpractice insurance is no longer a problem, however.

First, another cycle of cost increases and availability problems could begin at any time. And second, premiums remain high and vary widely depending on the specialty involved and the physician's geographic location. For example, a Chicago neurosurgeon now pays almost $191,000 a year for the same coverage that a colleague in North Carolina obtains for about $28,000. I have included a table at the back of my prepared statement that gives some more examples.

But, medical malpractice is of concern for reasons other than provider insurance cost and availability. Consumers, attorneys, insurers, and health care providers are concerned with and often affected by, first, the additional health care spending associated with the practice of defensive medicine; second, the large number of injuries due to negligence; and third, the widespread agreement that the current system for compensating patients injured by negligent practices is neither efficient nor equitable.

Let me say a few words about each.

First, as the incidence and size of malpractice claims have risen, many believe that physicians have become increasingly defensive by placing greater emphasis on not making mistakes. Providers may be performing additional tests and treatment procedures, giv-

ing more attention to increased medical recordkeeping, spending more time with patients explaining alternative treatments, and refusing to treat high-risk patients. Some of these actions may in fact be desirable. But, when defensive medicine results in unnecessary procedures or limiting of services, the effect is undesirable.

The extent of such defensive medicine is unknown and estimates vary widely. Recently, the American Medical Association estimated that in 1989, physician defensive medical practices added $15.1 billion to health care spending. But, you can find much higher estimates elsewhere in journal articles.

Unfortunately, many people are injured each year through medical provider negligence. The most recent comprehensive study of the incidence of medical malpractice was done at Harvard University in a large sample of 1984 hospital discharges in the State of New York. And, as the chairman alluded to in his opening statement, that study found that 1 percent of the patients discharged had been injured due to provider negligence. An earlier study of hospital admissions in California reached similar conclusions.

The current patient compensation system is not very effective in dealing with these injuries. Many patients receive no compensation at all, as the chairman noted. In the Harvard study, only 1 of 8 of the injured patients filed a claim. Even when claims are pursued, their resolution is slow and expensive.

A GAO study of claims closed in 1984 found that the average time to resolve the claim was 25 months. Some took as long as 11 years. In over half the cases, plaintiff legal fees exceeded 30 percent of the payments to the injured party. In addition, the insurers also paid $800 million to investigate and defend the claims closed in 1984 as compared to $2.6 billion that they actually paid in the claims. If you add it all together, it turns out that the lawyers and the overhead account for about almost half of the payments made.

In recent years, most States have responded to malpractice problems with some sort of tort reform. For the most part, these reforms have been designed to reduce the rate of increase in insurance premiums by reducing the number of claims filed and the size of malpractice awards and settlements. These particular tort reforms do not necessarily reduce the number of patient injuries nor the economic losses associated with those injuries.

The reforms that seem most effective are, first, caps on the total amount of the award or on the portion of the award that goes to compensate noneconomic losses such as pain and suffering. Second, prohibitions against receiving duplicate payments for the same injury which is called the collateral source rule, and third, reductions in the statute of limitations for filing claims.

The Federal Government has also instituted reforms designed to make it easier to identify negligent providers and prevent their moving from one State to another. Legislation enacted in 1986 created the National Practitioner Data Bank which contains information on disciplinary actions and medical malpractice claims.

Some States and private sector organizations have initiated other efforts to address the problems associated with an inefficient and inequitable compensation system and the adverse effects on the way physicians practice medicine. Receiving the greatest amount of attention are risk management at Harvard medical institutions,

the use of practice guidelines in Maine, fault-based alternatives to litigation in several States and some health maintenance organizations, and no-fault alternatives to litigation in Virginia and Florida. Each is described in more detail in my prepared statement.

Let me just say that none of the efforts yet provide a model that addresses all of the problems associated with how patients are compensated and the way physicians practice medicine. But the experience to date does provide insights that may be helpful as the Congress considers the various malpractice reform proposals.

The risk management program for anesthesiology at Harvard suggests that aggressive efforts to develop and implement clinical standards as part of the risk management program can reduce injuries and death and reduce malpractice insurance costs.

The practice guidelines demonstration project in Maine is a significant test of the viability of the concept of incorporating standards of care into law for application in medical malpractice lawsuits. In that project, physicians are to be given immunity from litigation when they practice according to the physician developed practice guidelines. Maine's ability to get the project implemented suggests the importance of using voluntary physician-generated rather than government-generated standards for judging physicians' clinical performance.

Michigan has had the most extensive use of voluntary arbitration. Michigan's experience suggests that when voluntary alternative systems operate parallel to litigation, the voluntary systems tend not to be selected. Further, there appears to be little potential for increasing participation in the Michigan program because it offers few incentives for the patient to choose arbitration over litigation.

Linking mandatory arbitration to the provision of health care, as is done by health maintenance organizations, may provide an acceptable alternative to litigation. However, we know less than we would like to about these approaches because the major HMOs using them have been reluctant to share data with us.

Virginia and Florida have no-fault programs which are relatively new and are directed only at claims involving neurologically injured infants. Their establishment is an important beginning in testing a system that provides compensation to patients when a specific injury occurs without having to prove that the provider was negligent.

Further, their experience suggests that it is possible to structure a program that defines an event broadly enough to include the intended injuries while defining it narrowly enough to control costs.

Mr. Chairman, the implications of medical malpractice are far-reaching. No matter what approach is taken to reform the system, it should address fundamental issues such as how to reduce the incidence of negligent care and how to compensate individuals fairly and efficiently who are victims of medical malpractice.

That concludes my summary of my prepared statement. I would be happy to answer any questions.

[The prepared statement and attachments follow:]

TESTIMONY OF LAWRENCE H. THOMPSON
ASSISTANT COMPTROLLER GENERAL, HUMAN RESOURCES DIVISION
U.S. GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss our views on the problems created by medical malpractice and on efforts to address aspects of these problems, particularly as these efforts pertain to the cost and quality of health care and have implications for reforming the health care system.

A major challenge facing the new Congress and administration is finding a better way to manage and finance the U.S. health care system while preserving the high quality, innovative medical care the United States has achieved. It is expected that this country will spend over $900 billion on health care this year, and if the present growth rate continues, health expenditures will exceed $1.7 trillion by the year 2000. These growing costs are being shared by individuals and the business community as well as federal and state governments.

The precise extent to which medical malpractice has contributed to the nation's spiralling health care bill is unknown. But there is little question that the costs associated with it run into the billions of dollars. The United States faces higher costs for medical malpractice insurance and associated defensive medicine costs than other nations. Of equal importance are the profound effects that medical malpractice is having on the way medicine is practiced in this country--effects that can be expected to grow in the future if the malpractice system is not reformed.

Today I want to share with you our views on

-- the relationship between the insurance crisis and malpractice problems,

-- the extent of the malpractice problem,

-- dealing with the practice of negligent medicine,

-- flaws in the current system for resolving malpractice claims,

-- the effect the malpractice problem has on the practice of medicine, and

-- efforts to try to improve the claims resolution process and improve the way physicians provide care.

Our testimony is based primarily on our earlier extensive work on the medical malpractice insurance problem. More recently, we have looked at some alternatives to the litigation system for resolving malpractice claims. We are continuing to address the malpractice issue through a variety of studies focused on such areas as practice guidelines, claims experience for Medicare and Medicaid patients, and insurance coverage for federally-supported health centers. Collectively, our work shows that malpractice is a difficult and complex problem.

MALPRACTICE IS MORE THAN A PROBLEM OF COSTLY INSURANCE

During the last 20 years, the issue of medical malpractice has been largely identified in terms of the cost and availability of malpractice insurance. But these are just two aspects of a multi-dimensional problem.

Medical malpractice was termed a crisis in the mid-1970s, when the premiums in some specialties rose several hundred percent in a single year and many insurers stopped selling malpractice insurance. As a result, many physicians could not obtain

coverage from their traditional insurers, or even if available, they could not afford it.

In response to this crisis, all states but one enacted legislation addressing the problem. The emphasis was on measures to create alternative sources of insurance and to reduce the number and cost of claims. Another response to this problem was for physicians and hospitals to create their own insurance companies to provide malpractice insurance. Over the next decade, these responses helped to make insurance more readily available in a market that is now dominated by these provider-owned companies.

Although the number and cost of malpractice claims continued to climb in the early to mid-1980s, insurers kept premium increases to a minimum because investments made at high interest rates were returning high yields. This changed, however, when interest rates began to decline in 1984. In response, insurers once again imposed large premium increases on health care providers. This was labeled as a crisis of affordability of insurance.

Physicians' malpractice insurance costs increased from $2.0 billion in 1983 to $5.9 billion in 1990 and hospitals' insurance costs increased from $800 million in 1983 to $2.1 billion in 1990. Although premium rates declined somewhat in the late 1980s, the cost of insurance remains high.

Physician malpractice insurance premiums vary widely depending on the specialty involved and the physician's geographic location. For example, a Chicago neurosurgeon now pays almost $191,000 annually for the same coverage a colleague in North Carolina obtains for about $28,000. (Attachment I illustrates these variations in rates.) These premiums represent uniform rates paid by all physicians in a given medical specialty and defined geographical area. They are not based on an individual's own claims experience.

The implications of the medical malpractice problem go well beyond insurance issues as demonstrated by the views of groups primarily affected by malpractice--consumers, attorneys, insurers, and health care providers. Consumers are concerned about the quality of medical care they are receiving and the long time required to settle malpractice claims. Attorneys believe that the large number of medical injuries due to negligence is the basic issue in discussions of malpractice. Insurers are concerned about the effects the unpredictability of the tort system has on insurance rate-making. Physicians and hospitals believe that malpractice insurance costs too much, patients' expectations are unrealistic, awards are excessive, claims take too long to settle, and legal costs to defend against claims are too high.

NEGLIGENT MEDICAL PRACTICES
MUST BE ADDRESSED

Malpractice claims are not a true indication of the extent of medical injuries due to negligence. Further, a claim does not necessarily indicate the existence of medical malpractice or the need for disciplinary action. But, the large number of injuries in relation to the small number of malpractice claims and disciplinary actions suggests that the current system does not do a good job identifying and disciplining negligent providers.

A Harvard University study of medical malpractice in New York indicated that, as a percentage of 1984 hospital discharges, the

rate of negligence by providers was 1 percent.[1] Further, the Harvard study found that the number of malpractice claims filed was far less than the actual level of negligently-caused injuries. These findings are consistent with the findings of the other major study of this subject, which involved an analysis of 1974 hospital admissions in California.

While 1 percent may not appear to be large, it is significant considering the effects of medical injuries on individuals. In New York, it represented about 27,000 patients found to be injured as a result of medical negligence. The Harvard data would suggest that, nationally, there were an estimated 150,000 fatalities and 30,000 serious injuries in 1984 caused by physician or hospital negligence.[2]

Despite the large number of fatalities and serious injuries attributable to negligence, few disciplinary actions were taken against practicing physicians. The Federation of State Medical Boards reported that a total of 2,108 disciplinary actions were taken against physicians in 1985. Of the nation's 552,716 licensed physicians, the Federation reported that state medical boards in 1985 revoked the licenses of 406, suspended the licenses of 235, placed on probation 491, and penalized 976--in ways ranging from reprimands to restrictions on practicing, such as preclusion from performing certain procedures.[3]

State medical boards, which are responsible for imposing sanctions on physicians found to be incompetent or impaired by debilitating conditions such as alcoholism, drug abuse, or mental illness, are often criticized for not doing more. But, before they can impose sanctions against physicians, negligent actions or impaired performance must be reported to them. To date, many health care providers have been reluctant to speak out against their colleagues.

Federal Actions to Help
Identify Negligent Providers

The Health Care Quality Improvement Act of 1986 and the Medicare and Medicaid Patient and Program Protection Act of 1987 were significant legislative attempts to facilitate the identification and reporting of providers who are practicing substandard medicine. The centerpiece of the 1986 legislation is the National Practitioner Data Bank, which contains information on disciplinary actions taken by state licensing boards, actions by hospitals and other institutions to deny or revoke clinical privileges, and medical malpractice claims paid by insurance companies that involve a licensed practitioner. Information contained in the data bank is expected to restrict providers' ability to move from state to state without discovery of their previous damaging or negligent performance. The act also seeks to facilitate the identification and reporting of incompetent practitioners by granting immunity from liability to individuals participating in peer review activities.

The data bank became operational in September 1990. As of May 7, 1993, the data bank contained 57,793 reports. Of these reports, 48,435 are for medical malpractice payments and 9,358

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[1]Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York, A Report by the Harvard Medical Practice Study to the State of New York, Feb. 1990.

[2]Paul C. Weiler, Medical Malpractice on Trial, Harvard University Press, Cambridge, Mass., 1991.

[3]In 1991, state medical boards took 2,804 prejudicial disciplinary actions against physicians, ranging from license revocation to a letter of warning.

are for adverse actions including those pertaining to licensure (6,729), clinical privileges (2,523), and professional society membership (106).

In addition to setting up the data bank, the Congress took steps to try to protect Medicare and Medicaid patients from practitioners whose licenses were revoked or suspended by another state's licensing board because they did not meet minimum professional standards. The 1987 legislation authorized the Department of Health and Human Services to establish national exclusions from Medicare and Medicaid of practitioners who are excluded from either program, convicted of crimes involving federal or nonfederal programs, or disciplined by state licensing boards. The Department has decided to include data regarding state disciplinary licensure actions under this act in the data bank. In fiscal year 1992, Peer Review Organizations took the punitive approach of recommending that the Department of Health and Human Services exclude a physician from further participation in the Medicare and Medicaid program 14 times.

THE COMPENSATION SYSTEM FOR THOSE INJURED BY MEDICAL NEGLIGENCE NEEDS IMPROVEMENT

In addition to addressing negligent medical practices, the system for compensating patients injured by negligent practices needs to be improved. There is widespread agreement that the current system is neither efficient nor equitable. Claims take a long time to be resolved, legal costs are high, and settlements and awards are unpredictable. Further, there are concerns about whether the system serves as a deterrent to the negligent practice of medicine.

Since the mid-1970s, every state has revised its tort system to address the medical malpractice insurance problem. Despite these reforms, it continues to take a long time for claims to be resolved and the cost of resolving them is high.[4] Our work showed that, for claims closed in 1984, it took an average of 25 months, with a range of up to 11 years, from the date a claim is filed until final resolution. Also, insurers paid $800 million to investigate and defend claims closed in 1984. Such costs were in addition to the companies' total claim payments of $2.6 billion.

Concerning the equity of the system, studies have shown that only a small proportion of injuries due to malpractice result in claims or lawsuits. Harvard researchers have corroborated the findings of previous research that many claims are not being filed even though they may be justified. Specifically, the Harvard study pointed out that only 1 of 8 patients admitted to New York hospitals in 1984 who suffered injury from negligence filed a claim. About 16 times as many patients suffered an injury from negligence as received compensation through the New York tort system. Thus, the tort system does not reach many individuals who are injured by medical negligence.

In addition, we found that even when a claim is successfully pursued, a large proportion of claim proceeds do not go to the injured parties. In over half the claims that were closed in 1984, plaintiff legal fees exceeded 30 percent of the payments to the injured party. Plaintiffs, in addition to their attorney fees, were responsible for paying other expenses, such as court costs and the costs of obtaining evidence.

Finally, questions have been raised as to whether the tort system actually provides an effective deterrent to malpractice. One of

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[4]Medical Malpractice: A Framework for Action (GAO/HRD-87-73, May 20, 1987).

the system's fundamental objectives is to deter negligent behavior by requiring parties causing injury through negligence to pay damages to the injured patients. However, in regard to medical malpractice, health care providers' liability insurance may insulate them from most of the financial effects of their negligent behavior. Moreover, malpractice insurance companies do not generally vary rates based on an individual physician's claims experience, and most premium costs are ultimately borne by consumers, insurers, and the public sector. This further reduces the deterrent effect.

MALPRACTICE CONTINUES TO AFFECT THE PRACTICE OF MEDICINE

The high cost of malpractice insurance and the threat of litigation have affected how providers deliver care to their patients. But views differ on the extent to which these changes improve the quality of medical services provided, decrease the incidence of negligent medical practice, or unnecessarily add to the cost of delivering health care.

As the quality of care delivered by institutions and individuals has become more closely monitored, some believe providers have become increasingly defensive. Placing greater emphasis on not making mistakes, providers may be performing additional tests and treatment procedures, giving more attention to increased medical recordkeeping, spending more time with patients explaining alternative treatments, obtaining patients' informed consent, and refusing to treat certain high-risk patients. Some of these actions may, in fact, be desirable. But when defensive medicine results in providers' performing unnecessary procedures or limiting services to high-risk individuals or underserved groups, the effect is undesirable.

The extent to which physicians practice defensively is unknown and estimates of the costs of such practices vary. The American Medical Association estimated that in 1989, costs associated with physician defensive medicine practices were about $15.1 billion. Much higher estimates have been cited in both the general media and medical publications.

Quality Assurance Activities Helpful in Reducing the Potential for Malpractice

Concerns about the threat of malpractice claims and associated financial losses have been a motivating force in the development of quality assurance activities. Among the many activities being carried out to help assure that the quality of health care remains high are two that could be particularly helpful in reducing the potential for medical malpractice--the refinement of risk management activities and the development of practice guidelines.

Risk management programs were initiated in the 1970s to reduce the potential for medical malpractice in hospitals. They are used by hospital management to identify, assess, and reduce areas of practice where patients are at highest risk of injury. Many organizations that deal directly or indirectly with hospitals believe that risk management helps reduce the incidence of malpractice and are taking an active role to either require or encourage the implementation of risk management programs or functions. These organizations include the Joint Commission on Accreditation of Healthcare Organizations, several states, insurance companies, and the Department of Health and Human Services. The American Medical Association, numerous medical specialty societies, and other elements of organized medicine are also involved in promoting the use of risk management in physician offices.

Although there is little direct evidence showing that implementing hospital risk-management programs reduces the number of accidents and malpractice claims, a study of acute-care general hospitals in Maryland reported that in-hospital educational programs targeted toward physician and nurse responsibilities in quality-assurance and risk-management activities correlated with fewer paid claims against hospitals.[5]

In addition to risk management programs, practice guidelines can help improve the quality of care provided to patients. Practice guidelines assist physicians in determining how diseases, disorders, and other health conditions can most effectively be prevented, diagnosed, treated, and clinically managed. They can also assist physicians in their efforts to improve service to patients, avoid unnecessary patient injury, and reduce the frequency of litigation. The American College of Physicians has been a strong proponent of their development and, along with other advocates, believes that their use has resulted in fewer malpractice claims and lower insurance premiums. Developing these guidelines is a complex process that requires considerable consensus-building among practitioners within individual medical specialties. It will be some time before their full impact can be assessed.

EFFORTS TO ADDRESS PROBLEMS

States' primary response to malpractice problems has been tort reform. However, some states and private sector organizations have initiated other efforts to address the problems associated with an inefficient and inequitable compensation system and the adverse effects on the way physicians practice medicine. Four that are getting the greatest amount of attention are risk management at the Harvard medical institutions, the use of practice guidelines in Maine, fault-based alternatives to litigation in several states and some health maintenance organizations, and no-fault alternatives to litigation in Virginia and Florida.

States Enact Tort Reforms to Reduce Malpractice Insurance Costs

For the most part, tort reforms have been designed to reduce the rate of increase in medical malpractice insurance premiums by reducing the number of claims filed and the size of malpractice awards and settlements. Empirical studies suggest that some tort reforms have achieved these objectives. The following three reforms are noteworthy:

- -- A reform that caps either the total award or the portion of the award that goes to compensate such noneconomic losses as pain and suffering, reduces the size of awards and settlements.

- -- A reform of the collateral source rule prohibits claimants from receiving payment through the malpractice system for economic losses resulting from the injury if such losses have already been compensated from other sources such as health insurance or disability insurance. Because economic losses constitute such a major portion of awards, limiting their double recovery reduces the potential size of the award and settlement, making it less attractive to a plaintiff's attorney. As a result,

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[5]Laura L. Morlock and Faye E. Malitz, "Do Hospital Risk Management Programs Make a Difference?: Relationships Between Risk Management Program Activities and Hospital Malpractice Claims Experience," Law and Contemporary Problems, Duke University School of Law, Vol. 54, Number 2, Spring 1991.

collateral source reforms also have the effect of reducing the number of claims filed.

-- A reform of the statute of limitations that shortens the length of time allowed for filing a malpractice claim reduces the number of claims filed.

Tort reform efforts have had some effect on the number of claims filed and the amounts of awards and settlements. In addition, they may have been a contributing factor in the reduction of malpractice insurance premiums in the late 1980s. However, this has been achieved at the expense of injured patients and, very likely, without improvement in the efficiency of the tort system.

Harvard's Aggressive Risk Management Effort Reduces Costs Associated With Anesthesia-Related Injuries

Although anesthesia mishaps are relatively few in number, when they occur, they generally result in injuries more catastrophic than those experienced in other specialties, and may, therefore, be quite costly in terms of personal and financial loss. Reductions of anesthesia-related losses in some malpractice insurance programs appear to correlate with involvement by anesthesiologists in risk management and loss prevention activities and with the implementation of risk management interventions such as development of clinical standards.

A study conducted at Harvard University-affiliated hospitals by the Risk Management Foundation of the Harvard Medical Institutions reported that following the implementation of an aggressive risk management program in anesthesia, costs associated with anesthesia liability decreased and led to a marked reduction in malpractice insurance premiums for anesthesiologists.[6,7]

In 1983, the anesthesia chiefs from the Harvard teaching hospitals formed a risk management committee with a goal to minimize related accidents, errors, and patient injuries associated with anesthesia. The committee reviewed case summaries on prior malpractice claims provided by the Foundation. As a result of this review, the committee developed clinical standards for monitoring patients during anesthesia that were implemented throughout the Harvard system in the spring of 1985.

Following implementation of these standards, the average loss for anesthesia-related claims declined. For the period 1976 to 1985, the average anesthesia-related loss was about $153,000. In the 33 month-period following implementation of the standards, the average cost per claim was about $34,000. As a result, anesthesiologists in the Harvard system's insurance program saw their 1989 premiums cut by almost one-third over the previous year's rate.

The development of the anesthesia standards also helped to stimulate interest among other clinical departments, including obstetrics and radiology.

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[6]James F. Holzer, "Liability Insurance Issues in Anesthesiology," International Anesthesiology Clinics, Vol. 27, No. 3, Fall 1989.

[7]James F. Holzer, "The Advent of Clinical Standards for Professional Liability," Quality Review Bulletin, Vol. 16, No. 2, Feb. 1990.

Maine Uses Practice Guidelines
as a Strategy to Reduce Costs

Several states, including Vermont, Minnesota, and Maine, have turned to practice guidelines as one approach to reducing health care costs. Maine has progressed further than other states in developing and implementing the approach.[8]

Maine, like the rest of the country, was experiencing an alarming increase in the cost of health insurance. To respond to this problem, leaders in the state representing organizations that were affected by rising health care costs formed a coalition. The coalition was especially concerned about defensive medicine, which was identified as one of the factors leading to increased health care costs. Physicians' primary motivation for practicing defensive medicine is the uncertainty about the standard of care to which they will be held accountable if patients allege that injuries resulted from the physicians' failure to meet the acceptable standards of care. Fearing such allegations, physicians may be motivated to perform unnecessary tests and procedures to build a good record in the event they are sued for medical malpractice. The standard of care is usually established in court on a case-by-case basis through the testimony of expert witnesses.

The coalition believed that physicians could not be expected to change their practice patterns unless given some protection from litigation. They also believed that defensive medicine could be reduced and, ultimately, health care costs as well if (1) practice guidelines establishing the standard of care could be developed for some areas in which physicians most often practice defensive medicine and (2) physicians were given immunity from litigation when they practiced according to these guidelines.

Willing to give the concept a test, the Maine legislature established a 5-year demonstration project. Effective January 1, 1992, the standard of care is incorporated into law for 20 procedures in 4 specialties--obstetrics and gynecology, radiology, anesthesiology, and emergency medicine. Physicians choosing to participate in the demonstration project can use the guidelines as a legal or affirmative defense in a malpractice lawsuit. An affirmative defense in this context means that when a physician follows the practice guidelines, the physician has met the standard of care and thus there can be no negligence and no damages recovered.

Most of the state's physicians in the four specialties have signed up to participate. The guidelines have broad-based support among physicians because they participated in their development and the guidelines mirror those of their national medical specialty societies. Thus, nationally accepted standards of care are reflected in the Maine guidelines.

The Maine project shifts the focus to the question of compliance with the approved standard and away from determining the standard on a case-by-case basis using expert witnesses. Maine officials expect that by codifying the standard of care, physicians will know at the outset of patient encounters the standards to which they will be held legally accountable, thus eliminating their motivation to perform the unnecessary diagnostic tests and procedures that add to the cost of health care.

Legal issues surrounding this project will probably be litigated in the courts, including questions about whether restricting the use of guidelines to physicians in lawsuits is constitutional and whether expert witnesses can challenge the guidelines.

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[8] Medical Malpractice: Alternatives to Litigation (GAO/HRD-92-28, Jan. 10, 1992)

Malpractice insurers are concerned that if the use of practice guidelines as an affirmative defense is found to be unconstitutional, insurers may be held liable retrospectively for claims arising from care provided by the insured physicians.

States and Health Maintenance Organizations Turn to Arbitration as an Alternative to Litigation

Because of concerns about the efficiency and equity of the tort system for resolving medical malpractice claims and compensating injured parties, a number of states and health maintenance organizations have turned to fault-based alternatives to litigation--primarily, voluntary and mandatory arbitration.[9]

Under arbitration, neutral third parties or panels resolve disputes. While these decisionmakers usually operate with less formality than the courts, the legal principle is the same--an injured party must prove that a health care provider's negligence or fault caused the injury. Generally, parties to a dispute who choose arbitration for resolving claims do so voluntarily. However, some health maintenance organizations have mandated that subscribers use arbitration to resolve claims.

Voluntary binding arbitration

We found that while 15 states had implemented statutes specifically covering the voluntary arbitration of medical malpractice claims, only Michigan had any significant experience with the alternative. The Michigan legislature established the arbitration program because it believed arbitration would result in faster claims resolution and lower patient compensation payments and defense costs. They expected that this, in turn, would lead to lower malpractice insurance costs.

Michigan was unique among these 15 states in that it was the only one that (1) had a method to make patients aware of the arbitration option and (2) established a program to implement the statute's requirements. Yet, despite these efforts, few plaintiffs selected arbitration rather than litigation. We found that in the more than 14 years the program had been in effect, 882 medical malpractice claims had been filed for arbitration in Michigan compared to an estimated 20,000 claims that were filed for litigation.[10]

It was difficult to determine the effect of arbitration on the malpractice claims resolution process in Michigan because of the limited (1) number of claims that were filed for arbitration and (2) data that were available on both arbitrated and litigated claims.[11] However, we compared claims that were litigated and arbitrated in 1987 and 1988. We found that while it took less time to resolve arbitrated claims--the median time from claim filing to claim closing was 19 months for arbitration and 35 months for litigation--there was little difference in insurance companies' costs to defend the claims. In addition, arbitrated claims resulted in lower award payments to patients. (Attachment II provides more data on the arbitrated and litigated claims closed during 1987 and 1988.) During this period, malpractice insurance costs did not decrease, perhaps because the number of claims arbitrated was small.

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[9]Medical Malpractice: Alternatives to Litigation (GAO/HRD-92-28, Jan. 10, 1992)

[10]As of March 31, 1993, 985 medical malpractice claims had been filed for arbitration in Michigan's program.

[11]Medical Malpractice: Few Claims Resolved Through Michigan's Voluntary Arbitration Program (GAO/HRD-91-38, Dec. 27, 1990)

While arbitration is possible under statutes in 14 other states, none had a state-level program to assure that this alternative was offered to patients or to provide guidance, oversight, and documentation of arbitration activities. Interest group representatives we talked with indicated that arbitration appeared to be little used in these states.

Mandatory binding arbitration

Over 6 million enrollees at Kaiser Permanente and Ross-Loos accepted a mandatory arbitration provision as a condition of enrollment. While these health maintenance organizations would not provide detailed data on their malpractice claims experience, they indicated that they believe this alternative is successful because it results in faster claims resolution, lower defense costs, and more predictable and equitable decisions.

Plaintiffs in California challenged the (1) legality of requiring subscribers to health care plans to arbitrate claims and (2) constitutionality of an agreement that waives the right to a jury trial without express consent. However, the California supreme court found that such contracts were not illegal and did not violate the right to a jury trial.

Virginia and Florida Adopt No-Fault Programs to Address Rising Insurance Costs

In the 1980s malpractice insurance premiums were rising in Virginia and Florida, threatening the access to obstetrical care for some of their citizens. Many physicians could no longer afford to buy malpractice insurance. In some instances, such physicians stopped delivering babies. In addition, some insurers stopped writing new policies until the states took action to reduce the uncertainty and unpredictability of the risk associated with delivering seriously injured babies. To address these problems, both states enacted no-fault programs limited to resolving medical malpractice claims involving birth-related neurologically-injured infants.

No-fault programs are designed to remove the difficulty of proving that an injury resulted from a health care provider's negligence or fault. Generally, under the no-fault alternative, compensable injuries and compensation amounts are specified. After an injury has been established, it is not necessary to identify the cause.

In both the Virginia and Florida programs, claims involving neurologically-injured infants must be resolved through the no-fault process if (1) health care providers involved in the claims participate in the program and (2) the related injury meets the program's definition.

Virginia's program, which became effective in 1988, has had four claims filed as of May 14, 1993. Three have been accepted for compensation. The program has paid out less than $60,000. In contrast, Florida's program, which became effective in 1989, has had 59 claims filed as of April 30, 1993. Twenty-two have been accepted for compensation. The program has paid out over $3.5 million. A Florida program official stated that the requirement that hospitals and physicians provide information on the program's benefits has been a major factor contributing to the use of the program.

CONCLUSIONS

Mr. Chairman, as I have stated, costs for medical malpractice insurance and defensive medicine are higher in the United States than in other countries and undoubtedly contribute to our growing health care costs. Malpractice is more than an insurance problem. Providers may continue to practice substandard medicine

without detection. Patients who are injured by health care providers' negligence, face a compensation system that is inefficient and inequitable. Providers, wary of their patients and the threat of lawsuits, may perform tests and procedures that are medically unnecessary.

The efforts I have discussed to address the problems associated with how patients are compensated and the way physicians practice medicine are still evolving. But, their experience to date provides insights that may be helpful as the Congress considers various malpractice reform proposals.

-- Harvard's risk management program for anesthesia suggests that aggressive efforts to develop and implement clinical standards can reduce preventable injuries and death and reduce malpractice insurance costs.

-- The practice guidelines demonstration project in Maine is a significant test of the viability of the concept of incorporating standards of care into law for application in medical malpractice lawsuits. Maine's ability to get the project implemented suggests the importance of using voluntary, physician-generated--rather than government-generated--standards for judging physicians' clinical performance.

-- Michigan's experience suggests that when voluntary alternative systems operate parallel to litigation--they tend not to be selected. Further, there appears to be little potential for increasing participation in the Michigan program because it offers few incentives for patients to chose arbitration over litigation. When mandatory arbitration is linked to the provision of health care, as is done by some health maintenance organizations, experience suggests that it is an acceptable alternative to litigation.

-- While the Virginia and Florida programs are relatively new, their establishment is an important beginning in testing a system that provides compensation to patients when a specific injury occurs without having to prove that the provider was negligent. Further, their experience suggests that it is possible to structure a program that defines an event broadly enough to include the intended injuries, while defining it narrowly enough to control costs.

Mr. Chairman, the implications of medical malpractice are far reaching. No matter what approach is taken, reform of the malpractice system should address the fundamental issues of (1) reducing the incidence of negligent care, (2) fairly compensating individuals injured through medical negligence, and (3) dealing with the complexities involved in efforts to enhance the overall quality of care provided in this country.

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This concludes my prepared statement. We will be pleased to respond to your questions.

 ATTACHMENT I

MALPRACTICE INSURANCE PREMIUMS
ST. PAUL INSURANCE COMPANY
FOR SELECTED SPECIALTIES, AREAS, AND YEARS[a]

	1988	1989	1990	1991	1992	1993
Obstetrics						
Chicago	$156,580	$155,510	$155,512	$146,338	$140,561	$144,516
Minnesota	57,130	42,330	35,461	29,232	21,410	21,410
North Carolina	20,620	16,270	16,275	16,183	19,038	21,012
Neurosurgery						
Chicago	197,330	195,950	195,952	193,327	185,775	190,990
Minnesota	71,870	53,290	44,567	38,485	29,101	29,101
North Carolina	25,900	20,400	20,402	21,237	25,187	27,644
General Practice (No surgery)						
Chicago	20,110	20,050	20,053	21,106	23,089	23,769
Minnesota	7,560	5,720	4,888	4,547	3,883	3,883
North Carolina	2,900	2,350	2,352	2,642	3,377	3,701

[a]Premiums shown are for coverage of $1 million per occurrence and $1 million in aggregate for a policy year.

COMPARISON OF AWARD PAYMENTS, RESOLUTION TIMES, AND COSTS TO DEFEND FOR ARBITRATED AND LITIGATED CLAIMS CLOSED DURING 1987 AND 1988

Table II.1: Award Payments for Arbitrated and Litigated Claims

			Award payments[a]			
	Number of claims				Range	
Disposition	Total	Paid	Median	Average	Lowest	Highest
Arbitration	65	14	$43,120	$135,591	$1,500	$ 605,161
Litigation	471	85	69,500	148,862	767	1,600,000

[a]Excludes claims where payment was $0.

Table II.2: Resolution Times for Arbitrated and Litigated Claims

		Months to resolve[a]			
				Range	
Disposition	Number of claims[b]	Median	Average	Lowest	Highest
Arbitration[c]	65	19	26	8	105
Litigation	438	35	37	3	123

[a]Represents months from claim filing to claim closing.

[b]Does not include 33 litigated claims for which data were missing and could not be obtained.

[c]Michigan statute established a 6-month discovery period for arbitrated claims.

Table II.3: Costs to Defend Arbitrated and Litigated Claims

		Defense costs[a]			
				Range	
Disposition	Number of claims[b]	Median	Average	Lowest	Highest
Arbitration	53	$17,509	$23,509	$1,348	$98,273
Litigation	462	17,798	20,202	47	78,997

[a]Defense costs represent the costs reported by defense attorneys and insurance companies at the time the claim was closed.

[b]Does not include 12 arbitrated and 9 litigated claims for which data were missing and could not be obtained.

Chairman STARK. Thank you.

Are you familiar with this—I think you have referred to it—the Harvard study which was a report to the State of New York? Have you seen that?

Mr. THOMPSON. Yes, sir.

Chairman STARK. Do you have any sense of how accurate or how thorough that study was?

Mr. THOMPSON. My sense is that the experts believe that it is a fairly credible study. It is about as serious an attempt as has been made, and I don't know of anybody who has raised any fundamental criticisms of the findings of that study.

Chairman STARK. I would ask my colleagues for unanimous consent to include a summary of this 1990 study in the record and it would be my intention—it is not very long—to get all of you a copy. It is the result of a meeting we had in the committee a year or two ago and you may find it shed some interesting light on the topic before us.

[A copy of the Harvard Practice Study follows:]

PATIENTS, DOCTORS, AND LAWYERS:

MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK

A Report By the Harvard Medical Practice Study
To the State of New York

EXECUTIVE SUMMARY

Introduction

The Harvard Medical Practice Study, carried out under contract to the State of New York, was designed to inform the policy debate now going on in New York and elsewhere about how society can best deal with its medical injuries and malpractice. To do so, we had to understand and isolate the key issues and assumptions that divide the protagonists of the current tort system, a reformed tort system, and no-fault alternatives. We have not prejudged the feasibility of any such no-fault program for injured patients, nor have we endorsed the criticisms that are made about present day malpractice litigation. Rather, we believe we have provided relevant empirical data that will permit informed judgments and sound policy-making concerning this complex area.

The Study had four principal components:

1. A population based measure of the incidence of injuries resulting from medical interventions, which we called "adverse events," and a determination of the percentage of such events that resulted from fault or negligence of the physician or other provider.

2. A determination of the percentage of adverse events, both negligent and non-negligent, that led to claims and suits. In addition, we obtained information about the numbers of claims and suits by patients in whose hospital records we found no evidence of injury.

3. Measures of the costs of medical expenses, lost wages, and lost household production to the victims of medical injuries and to their families, and their compensation for such losses under current arrangements.

4. Estimates of the degree to which variations in the threat of litigation affected the incidence of adverse events.

The following summarizes some of our methods and major findings.

1. The incidence of adverse events

The hospital medical record review was key to estimating the incidence of adverse events associated with medical management. The record review focused on two critical issues: causation and negligence. We asked, "Was the patient's condition attributable to medical management rather than to the disease under treatment (causation)? Was negligence involved?"

In addition to establishing causation and negligence, we determined where injuries occurred, the types of injury and then the magnitude of disability experienced.

The review was conducted by teams of trained medical record administrators and nurses for the screening phase, and board-certified physicians for the physician-review phase.

Methods were devised to resolve the logistic problems that arose because of the infrequency of adverse events: we found efficient and reliable ways to sift through thousands of medical records to find the few that indicated the patient disability caused by medical management. We also developed ways to deal with the methodologic problems that arose: the medical record administrators had to make valid judgments regarding the presence of screening criteria and physicians had to make valid and reliable judgments about whether a patient's injury resulted at least in part from medical management, and, if so, whether management failed to meet a standard of medical care.

In order to make our results generalizable to the entire population of hospital discharges in New York, we **drew a probability sample of more than 31,000 hospital records.** Our ability to obtain such a sample was made possible by the

availability of the Statewide Planning and Research Cooperative System (SPARCS) data system. The basic sampling design of the Study was an implicitly stratified, systematic, two-stage cluster sample of discharges. We first selected hospitals with probabilities proportional to the number of non-psychiatric discharges and then secured the cooperation of all 51 hospitals selected. Records within hospitals were selected with three different sampling frequencies determined by patient age and diagnosis-related group (DRG). Using SPARCS information on patient discharges, we drew a sample with a distribution that conformed closely to the population on important hospital and patient characteristics.

We analyzed 30,121 (96%) of the 31,429 records selected for the study sample. After preliminary screening, physicians reviewed 7,743 records, from which a total of 1,133 adverse events were identified that occurred as a result of medical management in the hospital or required hospitalization for treatment. Of this group, 280 were judged to result from negligent care. Weighting these figures according to the sample plan, we estimated the incidence of adverse events for hospitalizations in New York in 1984 to be 3.7%, or a total of 98,609. Of these, 27.6%, 27,179 cases, or 1.0% of all hospital discharges, were due to negligence.

Physician confidence in the judgments of causation of adverse events spanned a broad range, but only 1.3% of all discharges were in the close-call range (defined as a confidence in causation of just under or just over 50-50). An even smaller fraction, 0.7% of discharges were close-call negligent adverse events, but they constituted a larger proportion of total negligent adverse events.

The majority of adverse events (57%) resulted in minimal and transient disability, but 14% of patients died at least in part as a result of their adverse event, and in another 9% the resultant disability lasted longer than 6 months. Based on these

figures, we estimated that about 2,500 cases of permanent total disability resulted from medical injury in New York hospitals in 1984. Further, we found evidence that medical injury contributed at least in part to the deaths of more than 13,000 patients in that year. Many of the deaths occurred in patients who had greatly shortened life expectancies from their underlying diseases, however. Negligent adverse events resulted, overall, in greater disability than did non-negligent events and were associated with 51% of all deaths from medical injury.

Risk factors

The risk of sustaining an adverse event increased with age. When rates were standardized for DRG level, persons over 65 years had twice the chance of sustaining an adverse event of those in the 16-44 years group. Newborns had half the adverse event rate of the 16-44 years group. The percent of adverse events resulting from negligence was increased in elderly patients. We found no gender differences in adverse event or negligence rates. Although the rates were higher in the self-pay group than in the insured categories, the differences were not significant. Blacks had higher rates of adverse events and adverse events resulting from negligence, but these differences overall were not significant. However, higher rates of adverse events and negligent events were found in hospitals that served a higher proportion of minority patients. At hospitals that cared for a mix of white and minority patients, blacks and whites had nearly identical rates.

Adverse event rates varied 10-fold between individual hospitals, when standardized for age and DRG level. Although standardized adverse event and negligence rates for small hospitals (fewer than 8,000 discharges/year) were less than for larger hospitals, these differences were not significant. Hospital ownership (private, non-profit, or government) also was not associated with significantly different rates of adverse

events. The fraction of adverse events due to negligence in government hospitals was 50% higher than in non-profit institutions, however, and three times that in proprietary hospitals. These differences were significant. The standardized rate of adverse events in upstate, non-MSA hospitals was one-third that of upstate metropolitan hospitals and less than one-fourth that in New York City. These differences were highly significant. The percent of adverse events due to negligence was not significantly different across regions. Non-teaching hospitals had half the adverse event rates of university or affiliated teaching hospitals, but university teaching hospitals had rates of negligence that were less than half those of the non-teaching or affiliated hospitals.

The nature of adverse events

Nearly half (47%) of all adverse events occurred in patients undergoing surgery, but the percent caused by negligence was lower than for non-surgical adverse events (17% vs 37%). Adverse events resulting from errors in diagnosis and in non-invasive treatment were judged to be due to negligence in over three-fourths of patients. Falls were considered due to negligence in 45% of instances.

The high rate of adverse events in patients over 65 years occurred in three categories: non-technical postoperative complications, complications of non-invasive therapy, and falls. A larger proportion of adverse events in younger patients was due to surgical failures. The operating room was the site of management for the highest fraction of adverse events, but relatively few of these were negligent. On the other hand, most (70%) adverse events in the emergency room resulted from negligence.

The most common type of error resulting in an adverse event was that involved in performing a procedure, but diagnostic errors and prevention errors were more likely to be judged

negligent, and to result in serious disability.

The more severe the degree of negligence the greater the likelihood of resultant serious disability (moderate impairment with recovery taking more than six months, permanent disability, or death).

2. Litigation data

We estimated that the incidence of malpractice claims filed by patients for the study year was between 2,967 and 3,888. Using these figures, together with the projected statewide number of injuries from medical negligence during the same period, we estimated that eight times as many patients suffered an injury from negligence as filed a malpractice claim in New York State. About 16 times as many patients suffered an injury from negligence as received compensation from the tort liability system.

These aggregate estimates understate the true size of the gap between the frequency of malpractice claims and the incidence of adverse events caused by negligence. When we identified the malpractice claims actually filed by patients in our sample and reviewed the judgments of our physician reviewers, we found that many cases in litigation were brought by patients in whose records we found no evidence of negligence or even of adverse events. Because the legal system has not yet resolved many of these cases, we do not have the information that would permit an assessment of the success of the tort litigation system in screening out claims with no negligence.

Confining our analysis to the adverse events that involved strong or certain evidence of negligence, however, we estimate that 12,859 injuries from medical negligence did not lead to malpractice claims. Of these injuries, 22% (2,833) occurred in patients under age 70 years who suffered moderate or greater incapacity. Our projections suggest that if this group of

patients had litigated, the malpractice claims frequency for year 1984 would have increased by 75%.

3. Economic Consequences of Medical Injury

Having documented from the medical records survey which patients were injured, and from the litigation survey which patients filed tort suits, we used the patient survey to determine from the patients themselves what losses they suffered as a result of these injuries and what compensation they received from non-tort sources. For that purpose we divided our patient sample into five categories -- worker, homemaker, child, retired, and disabled -- and assembled data about lost wages and fringe benefits, medical costs, lost household production, and levels of physical and functional impairment. Our data for that final category have not been analyzed for this Report.

We faced two major difficulties in this survey. First, we had to locate, in 1989, people who had been hospitalized in 1984 in order to interview them about their experience since 1984. In fact, we were successful in finding and interviewing 71% of all injured patients, a response rate which is quite respectable for a survey of this type.

Our second problem was how to disentangle the effects of the adverse event itself from those that were properly attributable to the underlying illness, which itself would naturally be expected to entail considerable medical costs, time off work, and inability to perform normal household tasks. Two different strategies were devised for this purpose. One was to interview a control group of uninjured patients who were matched with our "experimental" group on the relevant dimensions, thus permitting econometric analysis of the precise difference which the iatrogenic injury made in the aggregate economic experience of the two groups. While we have collected all the data for the two groups, we have not completed this analysis for purpose of presentation in this Report.

Instead our primary focus has been on an alternative method -- estimating the compensable losses that might be paid under a hypothetical no-fault plan in which each patient's experience was assessed individually (as would have to be done in a real no-fault program), and then totaled. For that purpose we had to make a number of assumptions about program design: two important ones are noted here. First, all financial losses and compensation received during the first six months from hospital admission were deleted. These short-term losses are likely reimbursed from other sources (e.g., sick pay for time off work). Further, this reduces the number of cases in which disentangling the effect of the injury from the underlying illness may be very difficult. Second, we assumed that a no-fault patient compensation scheme would involve a second insurer, standing behind primary sources of general medical or disability insurance.

Our key findings with respect to these two criteria were that the bulk of disabilities were of short duration -- e.g., 42% of absences from work lasted for less than a month and 76% lasted less than six months. However, the average economic losses were much larger in the smaller number of more serious or fatal disabilities. With respect to these longer-lasting disabilities, more than 85% of the medical bills were covered by some form of health insurance, but only 20% of the lost earnings, and no detectable portion of lost household production.

Our ultimate finding is that the present discounted value of the net compensable losses (past and future) suffered by patients injured in New York hospitals in 1984 amounted to $894 million (in 1989 dollars). These compensable losses consisted of $285 million in lost wages and fringe benefits, $103 million in uninsured medical costs, and $506 million in lost household production (the latter having been valued at the market wages earned by the working women in our patient cohort).

To provide some perspective for these figures, the malpractice premiums paid by New York doctors and hospitals in 1988 amounted to $850 million. When one includes the amount spent by self-insured hospitals and the health care organizations, the total malpractice insurance burden is over $1 billion. However, these tort costs incorporate two major factors not reflected in our estimate. One is damage for pain and suffering, which typically are not compensated under no-fault programs. The other component is administrative and legal expenses which definitely would be a significant factor over and above the patient's economic losses. The administrative share of claims costs in no-fault workers compensation is usually estimated to be around 20%, though we believe it would be somewhat higher for no-fault patient compensation.

Since the sample of injured and interviewed patients in our different categories was rather small despite the relatively large sample of 31,000 hospitalizations, the confidence intervals surrounding our point estimates are large: the figures might be as much as 50% less or 100% more than those presented.. On the other hand, the estimate of net wage losses and medical costs -- these being the items typically covered by a no-fault scheme, and even then not in full fault - totalled just $335 million. Thus, there is considerable room within the current tort "envelope" to adjust even for an outcome at the highly improbable outer limit of these confidence estimates.

4. Malpractice Litigation and Deterrence

We examined the presumed deterrent effects of the tort system in two ways -- a series of physician surveys as well as an econometric study that compared the rates of adverse events and negligent adverse events, on the one hand, with the threat of a claim on the other.

The physician surveys revealed that the overall perceived risk of being sued in a given year was 20%, approximately 3 times the actual risk of being sued. The perceived risk of suit for

negligent care was about 60%, a figure substantially greater than the actual risk of litigation from injuries caused by negligence. Additionally, perceived risk was significantly greater for high-risk specialties such as obstetrics, orthopedics and neurosurgery and for physicians in Nassau and Suffolk counties, lending credence to the responses.

Physicians who perceived themselves to be at greater risk of suit said that in the past ten years they had ordered more tests and procedures and reduced their practice scope more than had their colleagues with perceived risk.

The tort system's deterrence signal to physicians appeared mixed. For example, physicians often considered the severity of punishment to depend on whether a case went to trial or whether the media publicized it. The evidence was not clear, however, on whether the severity of the punishment and the actual transgression were related: most physicians perceived their suits as having arisen from circumstances beyond their control. Many seemed to believe that the threat of the tort system was too broad and lacked specificity.

Although physicians believed they practiced medicine defensively, they did not report long-term changes in their practice patterns as the result of a specific suit. Thus, it was not clear whether defensive medicine resulted from the malpractice environment or from other factors such as advances in the science and technology of medicine, changes in societal expectations as to what constitutes an appropriate level of care, or changes in Peer Review Organization (PRO), state and hospital requirements, or a combination of factors.

Another important finding concerned physician attitudes about iatrogenic injury and negligence. Physicians tended to equate a finding of negligence with a judgment of incompetence. Thus, although willing to admit that all doctors make mistakes, physicians were often unwilling to label substandard care as negligent and were opposed to compensation for iatrogenic injury.

The final part of our study examined the relationship between variations in claims rates and variationsin cost and in injury rates in the sample of study hospitals. We found some evidence that total cost per discharge was greater in hospitals that faced higher claims rates, although the relationship that we estimated was sensitive to how we specified the relationship. Even conceding that there is an effect on cost, however, does not tell us whether the effect is good or bad. On the one hand, greater efforts to prevent injuries or ameliorate the consequences of those that occur may well require greater resources. On the other hand, additional resources in response to a greater threat may simply represent wasteful defensive medicine and not contribute to a reduction in patient injuries.

The important test, therefore, is whether hospitals that face higher claims rates actually do exhibit lower injury rates. We find no evidence that they do, but the precision of our estimates is not good, and we cannot rule out the possibility that there are in fact substantially reduced rates of injuries at the hospitals in our sample with higher claims rates. More specifically, the point estimate relating injuries to claims is actually positive in most specifications and never close to significantly negative. However, the confidence intervals around the coefficient include values that would demonstrate substantial deterrence.

We illustrate how our data cannot rule out a substantial deterrent effect by choosing one of the relationships we estimated, that for the probability that an adverse event is negligent, controlling for a number of other hospital characteristics. The point estimate of the claims variable is slightly positive; however, if we reduce the point estimate by approximately one standard error, it shows substantial deterrence. In quantitative terms, the reduced estimate would suggest that, other things equal, hospitals in the highest quartile of claims rates would have about 24% fewer negligent

events (conditional upon an adverse event) as those in the lowest quartile.

Moreover, there may be a bias in our results toward showing no deterrent effect. Our goal was to determine whether there is a negative relationship between claims rates and injuries, but hospitals and physicians that have higher injury rates may have more claims filed against them. This possible positive relationship between injuries and claims would tend to mask any true deterrent effect. We have tested for this bias and do not find any evidence of it, but our test could simply be failing to detect it.

Finally, even if we had been able to conclude that our data ruled out all but a negligible deterrent effect, we could not conclude that abolishing the tort system would have no effect on injury rates. All the hospitals in our sample faced some threat of a claim if an injury occurred, and the most we could hope to learn was the effect on injury rates of variation in that threat. Abolishing the tort system could reduce that threat to zero (depending on what, if anything replaced it), and we cannot learn from our data what the effect of that might be.

Chairman STARK. Mr. Thompson, you state that according to the AMA, costs associated with defensive medicine were about $15 billion. Yet earlier this year, the Lewin group issued a report and they estimated that we have a savings over 5 years of $7 to $70 billion, depending on which of the malpractice reforms were implemented.

Can you comment on that Lewin study and perhaps give us some idea why the range of estimated savings is so wide?

Mr. THOMPSON. First of all, it is very difficult to estimate the amount of defensive medicine that exists because, of course, there is a fine line between the extent a doctor does more tests or spends more time with his patients. There is a fine line between what is an improvement in the quality of health care and what is excessive.

The AMA estimate is an update of an estimate prepared several years earlier which did some analyses of what doctors reported their behavior changes had been in the early 1980s. The result comes out to about $15 billion. As I said, you could, if you wanted to, criticize that study. We could be here all day with criticisms of the study but that probably isn't very productive. It may be the best shot that anybody can take.

Now, my understanding is that the Lewin people were then asked to look at several different forms of malpractice reforms and speculate or estimate the effect those might have on defensive medicine. They started with this number which is I think as good a number as you can get but a number which is not very solid.

And basically my sense is they speculated that some reforms would reduce that by about half, some of them maybe by only a quarter, and some of them by maybe three-quarters or four-fifths. And by doing the calculation of what one-half of 15 billion times 5 is, you get kind of a soft estimate in the ball park of what might happen to defensive medicine if you reformed malpractice.

Chairman STARK. On the other side of the coin, last year, California took less than two disciplinary actions per thousand physicians. In Florida, it was almost 10 disciplinary actions per thousand physicians and about 8.3 in Maryland. It would take a leap of faith, I think, to imply that California doctors are seven per thousand better than those practicing in Florida or Maryland.

And what in your opinion is the reason for so few disciplinary actions or the wide variance in dealing with disciplining doctors who may in fact not practice the highest quality of medicine?

Mr. THOMPSON. Well, as you know, there has always been a concern about the relatively low rate of official actions against physicians by State boards and a concern that physicians' colleagues were not coming forward or the State boards were not being as aggressive as they ought to be in dealing with negligent providers. Perhaps, even that they weren't outreaching to get the information necessary to find out there was a problem.

One interesting development recently is that, as a result of malpractice crises of the mid-1970s, physician-owned insurance companies were developed to provide malpractice insurance.

My understanding is they now provide more than half of the insurance. These companies, owned by doctors, have underwriting committees comprised of doctors and have begun to be somewhat more aggressive in denying coverage or in putting restrictions on

the practice of people they insure or in putting surcharges on the physicians they insure. I saw an estimate about that in 1985, of the physicians that sought insurance under these physician insurance companies, 3 percent in that year were under some sort of a restriction. This implies that when you get a group of doctors who have a financial incentive as they own the company, to take a hard look at their peers, they look a little harder than maybe the State boards do.

Chairman STARK. Thank you.

Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

I noted that you basically have done a review in the GAO study, of what you have looked at and others have done, from the mid-1980s until the present time. And that your statement was basically that there doesn't seem to be something out there that really does it and there has been a lot of different experimentation, especially recently, in looking at a number of models.

In any of the evidence that you have looked at in terms of what States are trying to do, does there appear to be an area that has not been utilized or an approach that hasn't been pursued perhaps because of legal concerns, antitrust problems, for example, or do you feel that your examination of the evidence has indicated that States have pretty well had an opportunity to pursue all options and that even with that open running field, they haven't been able to come up with something?

Does there seem to be a blank spot or an inability to move in certain directions because of antitrust or other prohibitions that States can't deal with on their own?

Mr. THOMPSON. First thing I would say is that a lot of what is going on in the States is relatively new so that there is some interesting ideas being developed. But it is too early to know how effective they will be. There are a lot more being tried than we can pass judgment on as to how effective it will be. A lot of people are excited about the prospect of the things being done in Maine.

Mr. THOMAS. For example, when you talk about things that work that are so self-evident I am embarrassed to talk about them, like a cap on rewards. Pretty obviously, if you cap the amount, you get a certain result. If you prohibit duplicate payments, that is a pretty obvious to make sure that the costs don't go up.

And when you reduce the statute of limitations, you have fewer people responding because you have shortened the timeframe in which they need to be aware of options available to them. So if that is the extent of things that work, we really haven't even begun to examine the things that fundamentally will produce positive behavior modification like the practice guideline study in Maine, which I guess is into its second year of 5.

Mr. THOMPSON. Right.

Mr. THOMAS. In your study, you talked about the Michigan alternate dispute resolution mechanism. Virginia and Florida have a narrow one in terms of a no-fault. Would you be comfortable, based on what you have observed so far, in terms of the alternate dispute resolution mechanisms that, if you are going to look at that as a possible solution, there are going to be mandatory rather than voluntary.

Mr. THOMPSON. Yes, sir. I wanted to get to that. The recitation you said there of what works is in the context of one narrow avenue here; that is, the tort reform issue where you reform the tort laws within the context of the tort system. All you are doing is making some modifications and then you can reduce outlays.

Mr. THOMAS. Has there been any discussion about what we can do fundamentally to this tort system rather than within the current tort system? Have you had any complaints from States, that they can't because of what we have?

Mr. THOMPSON. The Virginia and Florida alternatives are narrow experiments to move in the direction of a no-fault system. Frankly, one of the motivations for the Harvard study we were discussing earlier was the interest of the then health commissioner of New York State in exploring a no-fault system.

Let me say that on the alternative dispute resolution mechanisms, I think that I would agree with what you suggested; it is not clear how you use a voluntary one to have much serious effect here. If you are going to have one, you would have to explore how to do it on a mandatory basis and that does raise legal issues which are beyond my expertise. But, I know you get into the issue of under what circumstances can somebody waive their ability to recover.

Mr. THOMAS. There are ways to resolve that by allowing it to go to the courts eventually and then perhaps some procedure which would increase the threshold of desiring to go to the court, like having to pick up costs or something——

Mr. THOMPSON. I think California——

Mr. THOMAS [continuing]. And provide a two-stage structure.

Mr. THOMPSON. My understanding, in California, the ruling is that if you selected the HMO——

Mr. THOMAS. It has been declared a legal approach to dealing with it if in fact the HMO offered it, but obviously we are talking about a far broader level than a particular HMO. I didn't get a definitive answer on the question of blank areas of pursuing alternatives because of legal boundaries.

Ms. KLADIVA. I am not aware of any alternatives, fundamentally brand new ideas, that aren't being pursued. The no-fault idea is being pursued, but very—on a narrow basis so far. And, as you look abroad, you see several countries which have relied more extensively on that.

Mr. THOMAS. Based upon the evidence in front of you, have you found that antitrust laws tend to inhibit options? Did any of the material indicate that?

Ms. KLADIVA. No. As a matter of fact, the Health Care Quality Improvement Act of 1986 provided a specific provision for immunity to good faith peer review for PRO actions yet, despite that, there still is not an outpouring of cases that have been brought as a result of disciplinary actions or investigations as a result of such referrals and the National Practitioner Data Bank which is now collecting data for peer review reports, for actions that are taken by State medical boards.

And the medical malpractice claims contain relatively few cases in the 2 years that the data bank has now been collecting data that pertain to peer review actions where adverse actions have resulted.

Mr. THOMAS. Mr. Chairman, let me just close by saying, when you try to determine the savings with defensive medicine, it is a little bit like trying to determine the cause of an accident if two cars collide. Is the cost of accident just the damage to the cars and the repair costs, or do you include the direct delay of the people behind the accident in terms of product activity or do you include the direct and indirect delay of product activity?

Do you build in stress concerns because of the accident? So if someone was able to come up with a range of $7 to $70 billion of the cost of the defensive medicine, I think it is a little bit like determining the cost of an accident, it depends on how you define it.

It seems to me that the societal costs on any of these actions are far greater than most people realize if you pursued all of the parameters, especially and fundamentally people who decide because of the current system they are not going to practice medicine anymore. That is a fundamental cost to the system that is extremely difficult to determine.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Andrews.

Mr. ANDREWS. Well, I suppose that there are really two issues here that we are trying to discuss and get a handle on: First, is this issue of costs and to what degree does defensive medicine and the tort issue cause health care costs to rise.

Coming from an area that has a lot of doctors and health care providers, I have no question in my mind that defensive medicine does in fact increase costs far beyond what the direct costs of liability and legal exposure costs the system. I think most thoughtful people recognize that.

There is also a second issue here and that is in the sense of additionally trying to save on costs, trying to make the system more efficient and reward quality and punish inefficiencies in the system: the doctors who run 20 tests to diagnose a patient as opposed to a more efficient doctor who runs 2. To what degree are those 20 tests done because of defensive medicine?

Maybe no study will be able to determine that. But in that regard, getting to that doctor that is a step beyond inefficient and defensive and the doctor that commits a malpractice, that causes injury to a patient either by negligence or mistake.

Who has done the best job in your review of these studies of trying to deal with that balance? How do you get to that malpractice, doctor, and make sure that that patient has a full opportunity for recovery of his or her damages?

Mr. THOMPSON. I think the first point I would make is that the current tort system, is often defended as a system which is a financial incentive for physicians to practice good medicine because they will get sued if they don't. In practice, however, insurance, and the way the insurance is priced, pretty much offsets that.

Mr. ANDREWS. How do you mean? How so?

Mr. THOMPSON. Because the physicians tend to be rated on the basis of their specialty and their geographic location and we don't differentiate among neurosurgeons in Dallas. Now, if a particular neurosurgeon is deemed to be particularly risky, he might be denied coverage.

But the insurance companies have not really gone much into trying to fine tune the calculation of premiums and if you will, fiscally punish someone who is deemed to be a less careful physician.

As I said earlier, interestingly enough, the physician-owned companies have been a little more aggressive recently in actually denying coverage to some of their colleagues who they think are a risk.

Mr. ANDREWS. That raises a good point, has the medical community done a good job in any of these areas in punishing malpractice, in ferreting out a negligent doctor, in reviewing a specific case where it is egregious?

Mr. THOMPSON. Well, I think most people would say that the medical community has not been as aggressive as it might have been in trying to police itself. There has been a lot of concern that they have not policed themselves adequately.

Mr. ANDREWS. And would that help?

Mr. THOMPSON. Well, of course it would help. I think that the medical community is very supportive of the development of these practice guidelines, of basically working through what is the right thing to do in given situations, what are the expected protocols.

Mr. ANDREWS. I understand. I am glad you mentioned that. What is the best criticism of practice guidelines. Make the best case against that procedure.

Mr. THOMPSON. Well, first of all, there are those who believe it is cookbook medicine. They believe that what is the point of going to medical school for all those years and have all that training if somebody then gives a guideline and says, here, this is what you are supposed to do.

That is especially the case if they perceive it is being developed by a group of people who are not physicians and who are off in Washington doing things. It takes time to develop them. And, sometimes it is expensive to develop them. They have to be updated regularly because technology and the knowledge base grows.

So you have to have a mechanism that has credibility with the physician community and then you have to have a mechanism for continually reviewing and updating them. That is the best case I can give you against them.

Mr. ANDREWS. Thank you.

Chairman STARK. Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman. Mr. Thompson, the idea of changing to an enterprise liability system has been raised. And I am under the impression that New York and Massachusetts have gone to that system?

Ms. KLADIVA. I am not aware of that. I think there are certain systems within New York and within Massachusetts, primarily large hospital systems, that have their own captive insurance carrier that do something close to this, but the States have not done this.

Mr. KLECZKA. The Harvard study does not mention it occurring in New York. Have you looked at the idea of enterprise liability and could you give the committee your impression of moving to that system which, I think, could pose some problems?

Mr. THOMPSON. Well, we have not really looked at that in detail. Let me move forward anyway and give you my impressions.

Mr. KLECZKA. Please do.

Mr. THOMPSON. I think to the extent that you can come up with enterprises that are logical organizations to do this sort of thing. I think it is an approach with potential.

Mr. KLECZKA. And they would be the hospital, the insurer.

Mr. THOMPSON. The hospital, yes. Actually, if you move to managed care, you begin to develop the organizations that make sense then. Of course, that is the way the big staff model HMOs handle malpractice, but in the fee-for-service sector, you can take hospitals and the physicians associated with them. You don't pick up all physicians necessarily that way.

There are lots of procedures that are done on an outpatient basis and I am not sure the hospital can be held responsible for what goes on in a physician's office a long way away. But, to the extent you can move in that direction, it does facilitate some risk management, the kind of things that we mentioned with the Harvard anesthesiologist where you actually have an organized effort to uncover what is going wrong, what do we do to fix it, how do we relate to our patients and explain what the risks are and it is not just one doctor doing or not doing the right thing.

Indeed, in a hospital today, the care is provided not by one physician, but by a whole team and when the hospital itself then becomes the locus for responsibility, the hospital itself becomes responsible for making sure that the team functions as a team.

Mr. KLECZKA. But the hospital—I don't know. Who do we mean by hospital, maybe the administrator or some overseer is not in every surgical suite where the possibility of a malpractice injury could occur. And playing the devil's advocate, I would liken that to blaming the car for the accident and not the driver and to shift that liability to the hospital where they don't have a direct hands-on overseeing ability for every surgeon that might be working under their roof.

Mr. THOMPSON. Well, hospitals are supposed to. Those hospitals are supposed to check what their credentials are. You are not supposed to privilege a physician if you are not confident that that physician can practice good medicine. You are supposed to have quality assurance systems and risk management systems. This all has to be in place in order to be accredited by the Joint Commission.

Mr. KLECZKA. I am not sure when you have a situation where a physician is involved in repetitive medical practice-type incidents, but for the one slip of the knife and some examples, the wrong liver being taken out. The hospital just can't comprehend those before they happen, naturally.

Mr. THOMPSON. You are not going to reduce to zero the incidence of these things. Indicted in this Harvard study, 1 percent of the people were victims of negligence and 4 percent had bad things happen to them. About three quarters of the unfortunate events were accidents—might even be a slip of the scalpel—and only one quarter seemed to involve physician's negligence.

Mr. KLECZKA. The other item that was mentioned in your statement is the National Practitioner Data Bank which came into existence September of 1990. What has been the experience with the data bank? The reason I ask is on a recent news report here in Washington, there was a doctor, and I might not be accurate on the

facts, who left practice in Maryland because of some problems and ended up in D.C.

Similar instances could have occurred prior to the bank being in existence, but since 1990, what has been our experience? Has it been an effective tool? Is the list comprehensive?

Ms. KLADIVA. I think it is an effective tool to provide information. Fundamentally, the National Practitioner Data Bank is a tool for collecting data. But a hospital that has to credential and privilege physicians is required to query that data bank when there is an application for referrals and every 2 years at least thereafter.

It makes information available, but it fundamentally is not the entity that has the responsibility for excluding an individual from transferring across State lines, for example. It is not a licensing board.

Mr. KLECZKA. The bank does not have that authority. How can we assume compliance by hospitals? Do we get a lot of inquiries to the bank on physician movement?

Ms. KLADIVA. I think the bank has been overwhelmed with the inquiries it has had. In many cases those inquiries have been to establish a baseline so that when the bank first became operational, I think they were surprised by the number of inquiries.

Mr. KLECZKA. Thank you all for your testimony.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Grandy.

Mr. GRANDY. Thank you, Mr. Chairman.

Mr. Thompson, there are a couple of things that I noticed in the Harvard study that you did not mention in your testimony, at least not in your abbreviated version. I just want to perhaps maybe get your thoughts on this.

In the executive summary, I noticed it concluded they say the fraction of adverse events due to negligence in government hospitals was 50 percent higher than in nonprofit institutions, however, and three times that in proprietary hospitals.

Do you have any comments or conclusions on that or why the incidence of negligence in government hospitals would be greater? The inference would be that the more government is involved, the more likely you are to have an adverse event and I just wonder what conclusions if any GAO might draw from that.

Mr. THOMPSON. I wouldn't want to draw a GAO conclusion, and I haven't looked at that. If I looked at it, I would look for some combination of three things. When you are talking about New York, I would look to see to what extent the government hospitals in that study are the hospital corporation in New York City which has had financing problems.

The second thing I would like to look at is the patient mix in the hospitals and especially whether the proprietary hospitals have more of a severe patient mix than the government and nonprofit. I think the major teaching hospitals will be nonprofit or government hospitals in most places.

I would start with those two elements. It may well be that the financial difficulties of the government hospitals in New York State are reflected in somewhat lower quality care.

Mr. GRANDY. I guess the connection I am concerned about whether you can infer that if the more government is involved in the

management or at least the underwriting of the hospital's operations, the more likely you are to have adverse events and I say this in the light of the fact that this committee has imposed a 2-year freeze on Medicare reimbursement and particularly in areas such as rural Iowa where you have underreimbursement being a problem right now with the maintenance of quality care.

Just on the surface it would happen that there could be a connection drawn between the inability to provide funds for reimbursement and not just obviously rural hospitals, but veterans hospitals as well which have already suffered severe budget cuts whether or not we are not perhaps as a government aiding and abetting the potential for negligence and adverse events.

Mr. THOMPSON. I can't argue with the proposition that under funded hospitals might be at greater risk.

Mr. GRANDY. Let me ask you this and you might have said this, I didn't pick it up if you did. Did you draw any conclusions in your study as to the incident of negligence and adverse events as relates to age? In other words, are you more inclined to see incidence of negligence and malpractice claims in patients 65 and over?

Mr. THOMPSON. I think in the Harvard study the answer is yes.

Ms. KLADIVA. What the study suggests is that the individuals who are most likely to sustain injuries in the health care system are the older individuals and they are less likely to file claims than are other citizens.

Mr. GRANDY. But they are also more likely to have accidents wherever they are, right. I mean to some extent the older and frailer and sicker you get, the more likely you are going to be at risk.

Mr. THOMPSON. Yes. And you should know that if you look at what these incidents are that are being reported out of the Harvard study you will see things like infections that are picked up in the hospital or drug reactions and, especially with infections, older people are probably more prone to pick up an infection.

Mr. GRANDY. I would also note that under the litigation data I think this is page 6 of the summary, you say these aggregate estimates and this is talking about the number of malpractice claims, understate the true size of the gap between the frequency of malpractice claims and the incidents of adverse events caused by negligence and only identified the malpractice claims actually filed by patients. In our samples and in the judgment of physician reviewers we found that many cases in litigation were brought by patients in whose records we found no evidence of negligence or even of adverse events. That would suggest that there is an unidentifiable population of people who are bringing suits that have no basis to them. And yet they are in the system and it is hard to assess what they do to the overall cost of malpractice and conversely defensive medicine. Am I correct in making that assumption?

Mr. THOMPSON. Yes, sir that is the Harvard study.

Mr. GRANDY. I am quoting from the Harvard study, but I notice you didn't bring that up when you were referring to the Harvard study in your summary in front of the committee and I think it is important noting that at least from the data that we are using to under write and support some of the hearing information here that

we are talking about a potential of malpractice claims that were filed probably with no merit.

Mr. THOMPSON. Yes, sir. Now, they weren't able to follow up to find out what happened to those claims. We don't know whether they were dismissed. I suspect if you followed up you would find some of them got paid and I think that does underscore the sort of random element that exists in the compensation system in which a set of people who are injured don't file and don't get any compensation and other people for whom the Harvard researchers could find no evidence of negligence do file and some of them probably will get compensation.

Mr. GRANDY. Thank you, Mr. Chairman.

Chairman STARK. Mr. Levin.

Mr. LEVIN. No questions.

Chairman STARK. Mrs. Johnson.

Excuse me; Mr. McCrery.

Mr. MCCRERY. Mr. Chairman, I will defer to Mrs. Johnson if she is ready and she looks like she is ready to go.

Mrs. JOHNSON. I am ready.

Thank you very much, but I don't mind waiting.

Just to target down on the point my colleague from Iowa was making because I think this Harvard study is very interesting and it is unique as far as I know and it has been quoted ever since it was done. Of the 31,000 cases that they reviewed, there were 300 that they thought from the charts contained some evidence of negligence.

However, of the 47 malpractice cases that were filed from this set of 31,000 people, only 8 were in that 300. So I think it is really interesting that 39 of the 47 were filed with probably very little evidence of any negligence. So, I think the cost implications for the malpractice issue of this study are very, very sobering.

And who gets justice under this system is also a question that bursts out at you loud and clear. You did confirm what my friend Mr. Grandy said earlier that even within this study the elderly were particularly unlikely to have brought suit and particularly likely to have appeared to have suffered from some negligence in care. So I think the Harvard study is rightfully one of the drivers behind the issue of malpractice reform.

There are a couple of things specifically that I want to ask you in regard to your work in this area and I appreciate the quality of that work over many, many years for us. You mentioned the Harvard risk management study. You mentioned the apparently increasing effectiveness of the physician-owned insurance companies. You don't mention, however, looking at hospitals that have gone specifically from being physicians to becoming self-insured.

And from being familiar with a couple of instances of that in my own district, I am very impressed with how that model both reduces costs and reduces incidence because of the way in which oversight is exercised.

Could you comment on that? Are there many instances across the Nation—did you look at those models? What comment would you have on that as a guide for us?

Mr. THOMPSON. We have not looked at that. The logic of the case you make I find compelling that when you are self-insured or you

are a small group, you then take more seriously the need to do those things that people already know are effective in terms of risk management and getting your act together.

The Harvard hospitals I understand are self-insured. Those are the ones that, referring to risk management, started with anesthesiology, and I guess they are moving through the other specialties now.

Mrs. JOHNSON. Could you look at hospitals nationwide that have gone to self-insuring and look at them before and after in terms of incidence and costs?

Mr. THOMPSON. I don't know whether we can or not. We can certainly look to see whether we can do that.

Mrs. JOHNSON. If you would get back to me on that I would appreciate it because one of the issues that it raises is very directly relevant to the larger health care debate and particularly to the concept of managed competition which seeks to press those decisions back down to the professional level and hold the professional level both accountable for quality through better public information on outcomes and performance and satisfaction directly accountable for quality and incidence as well as for costs so I think that model its important.

Then, did you look at all at the impact or the price variations between medical malpractice insurance in, for instance, urban areas or areas where there is a concentration of high risk patients versus those areas where there is no such concentration? What are the cost differentials? What is the availability of care? What impact has malpractice liability had on access to care in high risk areas and in cost of care in high risk areas?

Mr. THOMPSON. My impression, Mrs. Johnson, is that the access issue, although a major concern during a couple of the cycles in the mid-1970s and 1980s, seems to have receded. The cost concern however has not and I did allude in dramatic differences from one place to another in what a physician has to pay each year for malpractice coverage.

We are talking about $191,000 for a neurosurgeon in Chicago versus about $28,000 for the same coverage in North Carolina.

Mrs. JOHNSON. Have you been able to look at demographic changes in terms of physician population of different specialty types that might correlate with those high costs? The reason I am asking is because anecdotally I am getting very clear evidence that older obstetricians in poor urban areas are unable to find successors to take over their practices. I think we need to look at that and one of the reasons they tell me is here in Washington the premiums of an obstetrician in a poor area are several times the obstetrician of the same age in a community 20-minutes away so there is no incentive to focus or practice in a poor district.

Lastly, do you have any information on the comparative expense of malpractice insurance in Canada versus the United States?

Ms. KLADIVA. We are presently conducting an international comparative study of looking at five countries one of which is Canada, also Sweden, New Zealand, Australia and the United Kingdom and that is part of what we are doing in that study.

Mrs. JOHNSON. There is no mainland European country amongst those?

Mr. THOMPSON. Sweden.

Mrs. JOHNSON. Well that is a small country. You ought to put Germany in there rather than Australia.

Ms. KLADIVA. We were trying to focus on countries that use the tort system like the United States did for resolving malpractice claims or who had completely converted to a no-fault system such as New Zealand. We were looking for things that might be instructive to us in trying to find a comparative basis from our health care system to theirs, the way they resolve claims versus the way we resolve them and actions they had taken.

Mr. THOMPSON. Mrs. Johnson, the tort system is basically English common law so you find it in the English-speaking countries. If you are going to look at how they dealt with reforming malpractice, except for Sweden, looking in the English countries then causes you to start with the same basic legal concepts.

If you go to continental Europe, you get an entirely different legal system which has a whole different system. It doesn't have juries making awards and things like that.

Mrs. JOHNSON. All right.

Will you then identify, because there are some significant differences between the system in Canada and the system in the United States, the appeals process and contingency fees and things like that?

Ms. KLADIVA. Yes, we are.

Mrs. JOHNSON. Thank you very much.

I look forward to the conclusions of that study.

Thank you, Mr. Chairman.

Chairman STARK. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman.

Just to follow up for a couple of minutes on the Harvard study and first of all, let me just ask is any one of you an attorney? Raise your hand?

Mr. THOMPSON. No.

Mr. MCCRERY. OK.

Mr. THOMPSON. I don't know if that is good or bad.

Mr. MCCRERY. For purposes of this hearing, it may not be the best situation, but we will do as well as we can. In your written testimony, you state that in the Harvard study it was reported that following the implementation of an aggressive risk management program in anesthesia, costs associated with anesthesia liability decreased and led to a marked reduction in malpractice insurance premiums for anesthesiologists.

My question is did you look at how this risk management was implemented and more particularly, what sanctions, if any, were there in this particular institution if a participating physician did not follow the guidelines?

Ms. KLADIVA. I think they were being enforced on a hospital by hospital basis by the chiefs of the anesthesia departments.

Mr. MCCRERY. What was the threat if the physician didn't follow the guidelines.

Ms. KLADIVA. None that I am aware of. These were standards that were voluntarily developed and agreed upon across the Harvard hospital system. And they were standards that were perceived to be valid and I think physicians had no difficulty in voluntarily

complying with them. I am not aware that there are any specific overbearing sanctions associated if one did not follow them. In other words they didn't lose their insurance if that is what you are thinking of, for example.

Mr. McCrery. Or were fired.

Ms. Kladiva. Not that we are aware of.

Mr. McCrery. So to your knowledge, it was simply a kind of peer pressure within the institution to get them participating physicians to follow the guidelines?

Ms. Kladiva. Yes, to my knowledge.

Mr. McCrery. In your oral testimony, you talked about voluntarily alternative dispute resolution methods and that they didn't really show much promise in terms of savings and then you went on and mentioned mandatory alternative dispute resolution methods, but you didn't elaborate on that. Did you find that if mandatory arbitration, for example, were used, that it was more effective?

Mr. Thompson. The mandatory alternatives that I am aware of are used by health maintenance organizations. Kaiser, on the west coast, requires you to agree to arbitration as a condition of joining their plan. And what I did allude to is that understandably they have not been terribly interested in releasing a great deal of data to us about what their experience has been. And, therefore, we have their testimony to the effect that this has produced lower costs, and speedier resolution, but we really can't verify that independently.

Mr. McCrery. OK. If we were to—let's try to clarify what we mean by mandatory alternative dispute resolution. Do we mean that—and let's put it in the context of tort reform.

Do we mean that before a plaintiff can bring an action in the court system, he must go through some sort of alternative dispute resolution method?

Mr. Thompson. You can't go to court. You have waived your right to go to court in the Kaiser situation.

Mr. McCrery. Let's not talk about the Kaiser in particular, let just talk about in general the concept in tort reform for medical malpractice reform of using alternative dispute resolution methods. We could make it mandatory, couldn't we, that parties enter into an alternative dispute resolution, let's just use arbitration, it is easier to say right now, make it mandatory that they go into arbitration to an arbitration proceeding but you don't necessarily have to make the findings of the arbitration proceeding binding on the parties. Correct?

Mr. Thompson. That is correct.

Ms. Kladiva. The distinction that we made in the work that we did is that there was voluntary binding arbitration or there was mandatory nonbinding arbitration. What you are talking about would fall into the category of mandatory nonbinding arbitration which is typically the structure that you see. What many States have done is referred to as pretrial screening panels.

Mr. McCrery. And what was your finding of the experience of mandatory nonbinding?

Ms. Kladiva. Mandatory nonbinding arbitration tends to be a prelude to litigation, unless there are some other conditions attached at the end. It is not viewed as being particularly cost-effec-

tive; it just adds additional time and steps to the process. I say, unless you add something to the end things such as saying that after you must go through a mandatory nonbinding arbitration procedure when you finish that if you are not happy with the result, then you may take this to court and get a trial de novo. Depending upon the way States with pretrial screening panels have structured it, the finding of the arbitration panel or the pretrial screening panel may, or may not, be introduced into evidence. It is much more effective when it can be introduced into evidence because in essence that sets up the notion that if you were the loser and you are not happy with the result, then you are going to court instead of just getting a clean slate and that makes it more prejudicial to then proceed to the court if you are not happy with the finding. And there may be some attachment to saying that you may go to court but if you do not get a substantially different verdict than you got from the arbitration panel, then you must pay some attendant legal fees or costs associated with that which makes it not a free shot.

Mr. McCrery. And it is your finding that if those conditions are attached to mandatory nonbinding arbitration or resolution, then it is more effective in controlling costs.

Ms. Kladiva. The views of the legal scholars who have reviewed this find that to be a more effective approach.

Mr. McCrery. Thank you very much.

Chairman Stark. If there are no further inquiries I also would like to thank the witnesses for their contribution and look forward to working with you in the future.

Our next witnesses will comprise a panel made up of Dr. Richard Corlin, vice speaker of the house of delegates of the American Medical Association; John Leech, a member of the board of trustees of the American Hospital Association; Lawrence Smarr, the executive director of the Physician Insurers Association of America; and Dr. Richard Green, a member of the American College of Obstetricians and Gynecologists.

I would like to welcome these gentlemen to the committee and whenever you are seated and comfortable, we will let Dr. Corlin lead off.

STATEMENT OF RICHARD F. CORLIN, M.D., VICE SPEAKER, HOUSE OF DELEGATES, AMERICAN MEDICAL ASSOCIATION

Dr. Corlin. Good morning, Mr. Chairman and members of the subcommittee. My name is Richard Corlin and I am a practicing gastroenterologist and vice speaker of the house of delegates of the American Medical Association.

On behalf of the AMA, I am pleased to have this opportunity to testify regarding the very serious problems of our Nation's professional liability system. In the 1990s we are beyond the point of asking whether there is a crisis in the current tort system. We have reached a point where action is needed.

Mr. Chairman, studies have affirmed that without substantial reform, the current system is unable to resolve medical liability claims effectively and efficiently. The AMA strongly believes that patients who have been injured due to negligence should be fairly compensated. Unfortunately the current tort system has failed to

provide fair or even any compensation in too many meritorious situations and legal and administrative costs unduly diminish legitimate awards.

Studies have shown that the average doctor has a 37 percent chance of being sued in his or her lifetime. This increases to 78 percent for an obstetrician. Society as a whole is also harmed by the present system. The spiraling costs generated by our Nation's dysfunctional liability system are borne by everyone.

We cannot long sustain six-figure liability premiums or the cost of defensive medicine.

The Lewin-VHI study indicates that decreasing defensive medicine could save $36 billion over the next 5 years. Likewise the threat of liability severely inhibits medical innovation and deprives health care professionals of certain pharmaceutical and medical devices needed to optimally treat patients.

The most serious societal harm caused by the liability system is reduced access to health care. Increasing premiums and the threat of liability have caused physicians to abandon practices and certain services in all areas of the country. These are real problems that unless the current liability system is fundamentally changed, effective health care reform will never be achieved.

Reforms that work such as those adopted in California and Indiana tell us that reform can produce dramatic effects by promoting settlement of valid claims, discouraging frivolous litigation and reducing the time required for claims resolution. Twenty years of State-by-State attempts at reform have failed and a nationwide solution must be enacted.

The AMA also believes that a fault-based system such as the one designed by the AMA specialty society medical liability project may provide a forum for dispute resolution that is more fair to both claimants and defendants. Such a system would also be more cost-effective and would better deter negligence and promote patient safety.

This system must not serve as a prelitigation addon and should require as a minimum that the result be admissible in court.

We are also encouraged by bills such as H.R. 1625 sponsored by Representative Nancy Johnson emphasizing expedited claims resolution. Finally, we want to address the concept of enterprise liability. While we support strengthening patient safety and risk management programs, we do not believe that this unproven theory represents any improvement whatsoever over the present system.

Its underlying principles are untested whereas the California model has proven to be effective in lowering premium costs, decreasing health care costs and bringing efficiency to the system.

Mr. Chairman and members of the subcommittee, the problems associated with excessive litigation are not new. The system is broken and it needs to be fixed. Action is needed to meet the needs of the injured patient who deserves to be fairly compensated to reduce the frictional cost of the process and to ensure that physicians can still offer medically necessary services for all of our patients.

The AMA appeals to the Congress to provide us with a rational and equitable means of resolving this crisis. The AMA appreciates the opportunity to appear before this subcommittee and at this time we would be pleased to respond to any questions.

Thank you.

Chairman STARK. Thank you.

[The prepared statement and attachments follow:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health
Committee on Ways and Means
United States House of Representatives

Presented by
Richard F. Corlin, MD

RE: Health Care Reform:
Issues Relating to Medical Malpractice

May 20, 1993

Mr. Chairman and Members of the Subcommittee:

My name is Richard F. Corlin, MD. I am a gastroenterologist in Santa Monica, California and Vice Speaker of the House of Delegates of the American Medical Association (AMA). Accompanying me is Hilary E. Lewis, JD, of the AMA's Division of Federal Legislation. On behalf of the AMA, I am pleased to have this opportunity to testify regarding the very serious problems that stem from our litigious society and our current system of resolving medical liability claims.

The current tort system as it exists in most jurisdictions does not accomplish any of the goals of dispute resolution -- access to legal process, compensation for those injured due to negligence, or deterrence of such negligence. The system is fraught with inequities. In fact, medical liability litigation, accurately dubbed "high stakes" litigation by the RAND Corporation, has created numerous problems for this country's health care system -- all to the detriment of patients, physicians, health care providers, society and the federal government (the largest single payor for health care in this country).

Defining the Problem

For many years, this country has grappled with the growing inability of the tort system to resolve medical liability claims in a fair, timely and effective manner. The debate has intensified during the past two decades as medical liability problems have reached crisis levels in many states, and as society has shouldered the "side effects" of the crisis.

In the 1990s, the issue of medical liability continues to be heated. Despite 20 years of reform efforts in the states, much remains to be done at the federal level. Every recent poll has demonstrated that the American public strongly supports effective medical liability reform as a component of health system reform. Studies conducted by the Harvard School of Public Health, the General Accounting Office (GAO), and the Department of Health and Human Services Task Force on Medical Malpractice and Insurance, just to name a few, concur with the following consensus: The current tort system, without substantial modification or reform, is unable to resolve medical liability claims effectively and efficiently.*

*These studies also reached agreement that the reform model adopted in California most effectively discourages frivolous claims, promotes settlement of valid claims and expedites claims resolution. These reforms include:

1) limitations of $250,000 on recovery of noneconomic damages;
2) mandatory offset of collateral sources of plaintiff compensation;
3) decreasing sliding scale regulation of attorney contingency fees; and
4) periodic payment for future award of damages.

It also is important to note what the problem is not -- medical negligence is not solely the fault of "bad" or "incompetent" doctors. Rather, studies have shown that all doctors, even the best doctors, can and do make mistakes. We submit that avoidable mistakes are never acceptable. The medical community -- and the medical liability insurance community -- is committed to continuing efforts to reduce the incidence of injury even further and strongly supports reform efforts to promote patient safety and identify incompetent or unethical physicians. Our efforts alone, however, are not enough to remedy the many harms that the current tort system perpetuates.

Patients Are Harmed

The AMA strongly believes that patients who have been injured due to negligence should be fairly compensated, and that our dispute resolution mechanisms should promote this goal. Unfortunately, the current tort system has failed the patient population.

> A February 1990 study by the Harvard School of Public Health of hospital admissions in 1984 shows that of the 1% of patients whose medical records indicated some negligent treatment, only 12.5% filed liability claims. Significantly, only half of those patients -- 6.25% -- received compensation from the tort liability system.
>
> Other data show that even when patients pursue compensation, other parties to the system reap disproportionate benefits. Attorneys' fees and expenses (both plaintiff and defendant) account for 38% of total monies spent on resolving medical liability claims. (See Appendix A.)
>
> Ironically, while our system ostensibly is designed to compensate the injured, the RAND Corporation estimates that only 43 cents of every dollar spent in medical liability litigation reaches injured patients.
>
> In addition, patients typically wait much too long for resolution of their claims -- six to ten years in most urban areas. The time and cost commitment involved in pursuing litigation impedes redress of injury and denies injured patients meaningful access to the legal system by discouraging attorneys from accepting cases where damages are not expected to be very high.

Physicians Are Harmed

Medical liability awards soared by more than 1000% from 1960 to 1984. A study reported in 1988 showed that the average doctor has a 37% chance of being sued for professional liability in his or her lifetime. This increases to 52% for a surgeon and 78% for an obstetrician.

Perhaps the most compelling evidence of the current system's failure is the fact that <u>a physician's chance of being sued for medical liability bears little relation to whether he or she has been negligent</u>. The Harvard data show that 80% of the claims for medical negligence filed in New York did <u>not</u> correspond with a negligent adverse event. Stated differently, of those plaintiffs who sued their doctors, only 20% had cases based on evidence of a negligent adverse event. These findings reinforce the GAO's estimate that nearly 60% of all claims filed against physicians are dismissed without a verdict, settlement or any payment of compensation in the plaintiff's favor (1987 GAO Report, "Medical Malpractice, Characteristics of Claims Closed in 1984"). The message implicit in these facts and figures is that the current tort system as it functions in most states is not effectively resolving medical liability claims or deterring medical negligence.

Society Is Harmed

<u>Costs</u> - Although patients, physicians, and health care providers are most directly harmed by the present liability system, society as a whole also is harmed. The spiraling costs generated by our nation's dysfunctional liability system are borne by everyone. One component of the cost issue is the exorbitant amount attributable to physicians' (and other providers') professional liability premiums, which have been a significant factor contributing to the growth in patients' medical and health care bills. In the 1980s, professional liability premiums were by far the fastest growing component of physicians' practice costs, increasing at an annual average rate of 15.1% between 1982 and 1989. (See Appendix B.) Average premiums paid by self-employed physicians tripled in the 1980s. The cost is especially heavy for some high-risk specialists whose premiums have reached as much as $200,000 annually.

Yet another aspect of the liability cost factor is the cost attributable to the practice referred to as "defensive medicine." Aptly named, defensive medicine is a phenomenon whereby physicians, faced

with a 38% chance of being sued regardless of the quality of care they provide, defend against future liability claims by providing services in cases where that care might not have been provided absent the fear of litigation. A study published in Medical Economics found that, as a result of this practice, 70% of physicians order more consultations, 66% order more diagnostic tests, 54% order more follow-up visits, and 28% perform procedures they ordinarily would have delegated to other medical personnel. The AMA estimates that this practice added an additional $15.1 billion to the cost of health care in 1989.**

According to a report prepared by Lewin-VHI released in February 1993, the health care delivery system could save a middle range estimate of $35.8 billion over the next five years by eliminating defensive medicine practices. Lewin estimates that 1991 liability premiums and self-insurance costs for physicians amounted to $6.9 billion, and for hospitals, $2.3 billion, for a total of $9.2 billion. The report also notes that the threat of litigation motivates some practices carried out by health care professionals, with liability reforms that reduce the potential of being sued more likely to modify physician practice patterns. Such reforms would thereby contribute substantial savings to the cost of health care, with $4.3 billion projected to be saved during the first year of 1994. Once achieved, the Lewin study predicts that additional tort reform savings will accrue at an accelerated rate as practice patterns begin to change. These assessments make it clear that medical liability reform does not represent a comprehensive solution to the problem of health care cost containment. Nevertheless, it has the potential to substantially contribute to reduction in the cost of health care.

Medical Innovation - Another societal harm that results from the present system is that the threat of liability acts to inhibit medical innovation and deprives health care professionals of certain pharmaceuticals and medical devices needed to optimally treat patients. Excessive litigation costs have been cited as the primary reason for the manufacturer of the morning sickness drug Bendectin to withdraw this product from the market, even though there is no credible scientific evidence to this day linking it to birth defects. Patients suffer needlessly as there also is no substitute therapy for morning sickness that has been developed -- the litigation risk is just too high.

Access to Health Care - Perhaps the most serious societal harm caused by the liability system is reduced access to health care. Increasing premiums and the threat of liability have caused physicians to abandon practices and to cease provision of certain services in various areas of the country. Access to health care includes: (1) the availability of a physician or other health care professional to treat a patient; (2) the willingness of the physician or other professional to treat a patient; and (3) the affordability of the medical services.

Physicians and health care institutions have limited their medical practices in response to the liability climate. These restrictions on access to health care services have been seriously felt by obstetric patients, indigent patients, and those living in rural areas. Almost one out of eight obstetrician/gynecologists (12%) has dropped obstetrical practice as a result of liability risks.[1] More than a half million residents of rural counties are without any physicians who provide obstetric services.[2] Nor is this phenomenon limited to rural areas. An example of this problem was presented by Senator Riegle while chairing a 1991 hearing on health system reform, when he indicated that his family was unable to remain with the obstetrician of choice because that physician gave up obstetric practice. This did not happen to a citizen in a rural community. It happened to a U.S. Senator in the District of Columbia.

The fear of being sued and the escalation of liability insurance premiums can also deter physicians from performing high risk procedures. For example, 24.2% of obstetrician/gynecologists have decreased the level of high risk obstetrical care provided, and 10.4% have decreased their number of deliveries.[3] The high cost of the current liability system is further reflected in the escalating cost of medical services. Liability insurance costs have caused one-third of physicians to avoid particular areas of medical practice, notwithstanding their professional qualifications to perform these procedures.[4]

The eagerly anticipated report of the White House Health Care Reform Task Force, as well as the flurry of current legislative initiatives on the subject of health system reform at both the federal and state levels, have moved this issue to the forefront of the domestic agenda. However, meaningful health care reform cannot be attained unless the irrationality and the waste in the current medical liability system are addressed concurrently. The AMA urges this Subcommittee to recognize that the present medical liability system significantly and directly impairs both access to health care and access

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**Like other defensive measures, all defensive medicine cannot be characterized necessarily as overuse, but can reflect necessary improvements and added value in the provision of patient care.

to a workable compensation system for victims of malpractice. Until the negative aspects of the liability environment are alleviated, these access issues never will be fully resolved.

The Federal Response

The medical community is actively carrying out its responsibility to work toward a solution to the medical professional liability disaster. We hope that the other participants in the system will heed the call to participate in this effort. Many states have been unable to effect reforms that can withstand state constitutional challenges. We believe, therefore, that the federal government must act to realize a viable solution to the panoply of issues raised by medical liability.

The litany of problems with the current tort system does not necessarily mean that the system must be abandoned. The AMA believes that a fault-based system that lowers the barriers to legitimate claims and reduces transaction costs can meet the needs of society. Reforms such as those adopted in the states of California and Indiana tell us that the current system is a good candidate for reform, and that reform can produce dramatic effects by promoting settlement of valid claims, discouraging frivolous litigation, and reducing the time required for claims resolution.

Federal Preemptive Tort Reform - The AMA supports federal legislative initiatives that create uniform standards of medical liability and preempt state law, except where corresponding provisions in state law are more effective. These uniform standards were incorporated in the 1975 California Medical Injury Compensation Reform Act (MICRA) and stand as a proven experiment in demonstrating what can be accomplished. The California reforms include: (1) limitations of $250,000 on recovery of noneconomic damage awards; (2) mandatory offset of collateral sources of plaintiff compensation; (3) a decreasing sliding scale regulation of attorney contingency fees; and (4) periodic payment for future award of damages. We believe that these standards should apply to any claim arising from health care services offered by health care professionals or institutional providers in any state or territory.

Federal preemptive tort reform represents a bold approach, but the only one which bears the potential for truly advancing a nationwide solution to this complex problem. The California experience is instructive in offering the following comparisons:

- Juries award more in medical malpractice cases than for the same injuries sustained in other contexts. Nationwide, there are more million-dollar-plus medical malpractice verdicts than any other type of personal injury claim. (Figure 1) In California, MICRA has decreased the number of million-dollar-plus verdicts per 1000 physicians to about half of the national average. (Figure 2)

- Nationwide, medical liability premiums constituted the fastest growing component of physicians' practice expenses in the 1980s. In California, however, MICRA reform succeeded in stabilizing and actually lowering (in real dollars) these insurance costs. (Figure 3) When MICRA was enacted in 1975, the medical liability premium costs in California were the highest in the nation. Today, they are one third to one half the costs of premiums paid in states without a MICRA-like cap. (Figure 4)

- Evidence suggests that California's MICRA reform has helped control the state's health care costs. From 1984 to 1986 -- the worst years of the last liability insurance crisis -- physician fees nationwide increased 13.1%, but only 9.2% in California. (Figure 5) In 1991, the California medical care services index was lower than the national average, although other state consumer costs were climbing at a higher rate than the national average. (Figure 6)

- In 1975, Ohio also enacted tort reforms similar to those in MICRA. At that time, medical liability awards in that state accounted for 3.7% of the nation's total. By 1982, that percentage dropped to 2.9% While constitutional challenges to MICRA were rejected by both the California Supreme Court and the United States Supreme Court, the Ohio Supreme Court struck down its $250,000 limit on noneconomic damages in 1982. By 1985, Ohio's percentage of nationwide payouts had grown to 5.4%. (Figure 7)

- While a $250,000 limit on noneconomic damages generates substantial savings, it affects very few potential claimants. The GAO found that in 1984, only 2% of medical liability cases nationwide produced noneconomic awards over $200,000. Yet these 2% of cases accounted for over 60% of total noneconomic payouts,

demonstrating the significant cost containment function of an appropriately placed cap. (Figure 8)

- Had the California MICRA reforms been indexed to inflation, they would have failed to lower the real cost of liability insurance. A linkage to the Consumer Price Index would have doubled the limit every ten years, bringing it to over $1 million by the turn of the century. (Figure 9) Wisconsin abandoned its inflation-indexed ceiling on noneconomic damages as it appeared to be having this effect.

- While it is appropriate to link economic elements of damages to increases in medical care costs and income, it does not follow that the noneconomic losses of "suffering" or "loss of enjoyment" are in any real sense subject to inflation. Few other countries allow compensation for noneconomic damages at all, and those that do impose severe restrictions on such payments. Expressed as a percentage of gross domestic product, U.S. tort costs are more than twice that of any other developed country and four times those of the United Kingdom. Moreover, U.S. tort costs continue to grow, while those in other countries have been stable. (Figures 10 and 11)

A virtual consensus exists among physicians, other health care professionals, and institutional providers that strong traditional tort reform represents an important first step toward reaching a more rational, cost-effective means for resolving medical liability claims, regardless of whatever innovative approaches to liability reform are also advanced. The AMA strongly supports the California model of medical liability reform as a proven experiment that has actually decreased the real (inflation-adjusted) cost of medical liability in that state.

Alternative Dispute Resolution Systems - The AMA believes that a fault-based administrative system, such as the one designed by the AMA/Specialty Society Medical Liability Project (AMA/SSMLP), may provide a forum and process for dispute resolution that is more fair to both claimants and defendants, more cost-effective, and more systematic in deterring medical negligence and promoting patient safety than the present system. We are pleased to note that an intensive analysis of the AMA/SSMLP model completed by the Georgetown University Centers for Medicine and Law corroborates these expectations. (See Appendix C.) We applaud the fact that experimentation with alternative dispute resolution (ADR) occupies a major role in various federal proposals advanced in the 103rd Congress, including H.R. 1625, the "Medical Malpractice Liability Reform Act of 1993," sponsored by Representative Nancy Johnson (R-CT), and H.R. 1572, the "Medical Care Injury Compensation Reform Act of 1993," introduced by Representative Jon Kyl (R-AZ).

The AMA supports investigation of ADR options that represent a true alternative to litigation, not as an add-on that permits unfettered access to the civil justice system by any party dissatisfied with an ADR result. Unfortunately, most voluntary or nonbinding ADR options considered to date have failed to divert claims from litigation, lower transaction costs, or expedite claims resolution.

Funding - The AMA opposes any funding mechanism for ADR demonstration projects based on population as it would severely disadvantage smaller states that have demonstrated a readiness to pursue ADR experiments. Our estimates indicate that an appropriation of $50 million, spread out over five years, may be sufficient to support demonstration projects in up to five states. Evaluation of their performance in selected sites after five years would be of value to all states, including those not currently positioned to implement such an experiment.

Patient Safety/Risk Management - Legislation designed to enhance patient safety would serve as a valuable adjunct to tort reforms addressing uniform standards of liability. The AMA supports the dedication of health care professional licensing fees to increase the effectiveness of state medical disciplinary boards. We also support the ability of states to enter into contracts with local professional societies to assist in investigating consumer complaints. The State of Maryland has implemented such a system, in which local committees of physicians operating as ad hoc agents of the state peer review complaints and make recommendations for action to the state licensing authority. Protected from the threat of antitrust exposure by a grant of sovereign immunity, programs such as the Maryland initiative have the potential to significantly enhance the resources of licensing and disciplinary boards.

Efforts to involve liability insurers, hospitals, medical societies and states in risk management programs may serve to further enhance patient safety. The AMA believes that any risk management activity must be carefully undertaken so that the physician's responsibility to provide quality patient care remains paramount. Physicians must be actively involved in developing and participating in risk management activities in order to achieve the goal for which they are created -- the provision of quality patient care. The medical profession remains committed to reducing the incidence of patient injury. In this context, we support required risk management training for health professionals and are

proceeding with aggressive endeavors to restrict the ability of unethical physicians to practice medicine.

Continuous quality management, as well as strengthening of the current public and private systems that gather and analyze data relating to patient risk factors, would further promote patient safety and quality of care. The Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), health care institutions, managed care organizations, professional societies, state licensing and disciplinary boards, and medical liability insurers have initiated programs to promote quality. These approaches include risk management education, professional oversight and review, and disciplinary activities. Federal medical liability reform initiatives should encourage these local quality management efforts.

Practice Parameters/Guidelines - At the present time, insufficient evidence exists to show that clinical practice guidelines can be developed in a manner specific enough to be introduced as an affirmative defense in medical liability litigation. Concerns arise that any governmental procedures utilized to endorse such guidelines may move too slowly to accommodate rapid changes in medical technology. If legal protection were afforded only to practices within government-approved parameters, medical treatment that embraces the newest scientific information may be discouraged.

Innovative local experiments with practice guidelines are now being tested in Maine, Minnesota, Florida, and Vermont. Physicians electing to participate in these demonstration projects will be able to assert compliance with practice parameters and risk management protocols as a legal defense in any medical liability suit brought against them during the years of the pilot programs. It is hoped that using practice parameters in this way will help to classify the standards of care applied by courts and discourage the practice of "defensive medicine" outside of approved parameters. The AMA believes that these state experiments should be supported by the federal government through the activities of the Agency for Health Care Policy and Research. By tracking the claims brought during the demonstration period, and comparing this data with data before the experiments took effect, appropriate determinations may be made on the efficacy of using practice guidelines as an affirmative defense.

Enterprise Liability

The concept of enterprise or "organizational" liability is currently garnering a great deal of attention. As originally developed by Professor Kenneth Abraham of the University of Virginia Law School and Professor Paul Weiler of Harvard Law School, the notion of enterprise liability focuses on legislatively transferring all medical liability exposure to the hospital institution which becomes the only defendant in a liability lawsuit, with individual physicians becoming witnesses in the litigation process. Under this construct, the institution would be empowered to implement and enforce patient safety/risk management education and regulation of its medical staff. Preliminary reports indicate that the National Health Care Task Force is extending the Abraham/Weiler model to vest the liability exposure and quality control responsibilities within accountable health plans (AHPs) instead of hospital institutions.

While the AMA fully supports the goal of strengthening patient safety and risk management efforts, it remains unclear whether AHPs or other entities will be more effective in achieving it, or that this approach will benefit patients or physicians in all delivery systems. We strongly believe that the more than forty physician-owned insurance companies are presently acting as the most effective supporters of patient safety programs in ambulatory care settings. AHPs may not be able to assume a similarly active role in the new context.

Another question arises as to how the current premium costs paid by physicians would be absorbed in an enterprise liability environment. Would AHPs be permitted to require health care professionals within an integrated system to sign "hold harmless" clauses indemnifying the AHP for any losses attributable to the negligence or fault of such professionals? If liability exposure were thus transferred back to physicians, the objectives of enterprise liability would not be served. Furthermore, if health care costs were passed on to physicians in the form of a surcharge, would AHPs be permitted to utilize "experience rating" for physicians involved in liability claims? If so, how would such "experience rating" be implemented?

Obviously, physicians must work in a coordinated manner within health care delivery systems to promote quality. Physicians should be encouraged to continue acting as patient advocates, especially where patient safety is at stake. All of the responsibility and control, however, should not be conferred on another entity, as is contemplated within the structure of enterprise liability. The role of physicians in promoting quality or patient safety in an enterprise liability scheme has yet to be defined.

In fact, the implementation of enterprise liability could eviscerate the important traditional function of physicians as advocates for their patients.

Enterprise liability may also increase the frequency and magnitude of medical liability claims as individuals become more willing to sue an anonymous "deep pocket." The AMA supports the objective of the current tort system in holding health care professionals to a high degree of personal responsibility for the welfare of their patients. We have long maintained that a fault-based malpractice system could serve a valuable deterrent function, as long as it is fair and cost-effective in delivering compensation to victims of negligence.

It would indeed be premature at this time to proceed with the yet untested principles underlying enterprise liability, especially when the viable California model of tort reform has actually decreased the real cost of medical liability in that state. We, therefore, urge that medical liability reform focus on clarifying the rules of damages and the standards of care presented in court cases, providing real access to a dispute resolution process for injured parties, and creating a workable mechanism for screening out nonmeritorious claims.

The Medical Community's Response

Mr. Chairman, all parties -- patients, lawyers, physicians and insurers -- must be willing to make compromises to craft an effective solution to the medical liability problem. We agree that the responsibility is a shared one, and acknowledge that it is the provider community's particular responsibility to do whatever it can to minimize the incidence of avoidable patient injury. (See Appendix D.)

Providing medical care today involves a complex system of persons and technology, each individual and component of which is necessary to bring about the safe and effective delivery of care to the patient. All of our activities aim at the common goal of preventing patient injury. All call upon us to examine what we do or fail to do, and how we do it. When problems are detected, solutions are developed and implemented.

We strongly believe that the patient safety movement currently being implemented by the medical community is the optimal source of information and education for providers on injury prevention issues. These activities are data-based, innovative and amenable to modification as new problems arise. To best prevent errors, we must study the facts of loss situations, identify high-risk circumstances, and educate physicians in a focused manner on how to avoid them.

Conclusion

Mr. Chairman, the problems associated with excessive litigation are not new to the medical profession. The medical liability bills being considered in the 103rd Congress, the Lewin study on defensive medicine, the Harvard Medical Practice study, and virtually every other study that has been completed all validate what physicians have been saying for 15 years -- the system is broken. It needs to be fixed.

Our liability system needs to be fixed to meet the needs of the injured patients who need to be fairly compensated, the physicians who are willing to assume their fair share of the burden from negligent practice, and society, which needs to reduce transaction costs, eliminate windfall judgments, and assure that physicians can still offer medically necessary services in an atmosphere of fairness to all parties.

The AMA appreciates the opportunity to appear before this Subcommittee. At this time, we will be pleased to respond to questions.

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End Notes

1.Professional Liability and its Effects: Report of a 1990 Survey of ACOG's Membership, American College of Obstetricians and Gynecologists

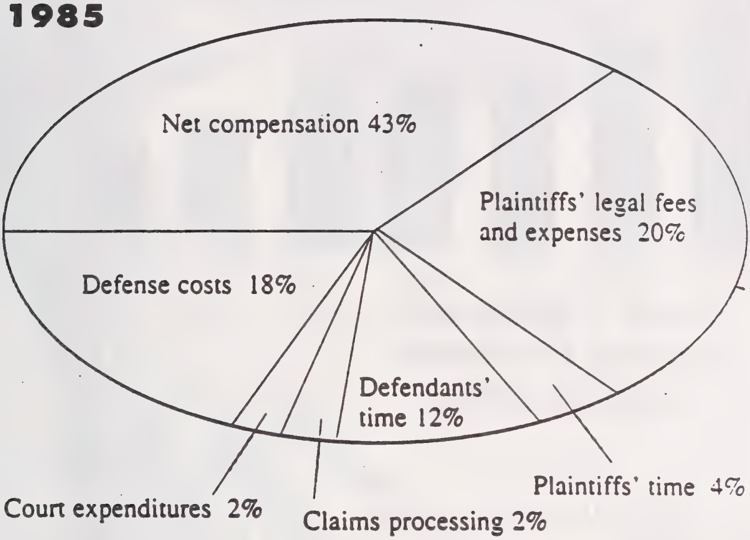
2.Health Care in Rural America, Office of Technology Assessment, September 1990

3.ACOG Survey, op.cit.

4.Harvey, L., et al., Physicians and Public Attitudes on Health Care Issues, American Medical Association, 1989

Appendix A

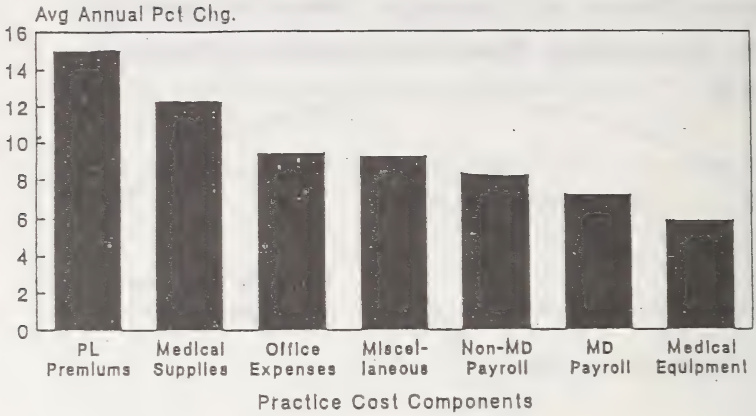
Plaintiffs' Net Compensation and Various Costs as a Percentage of Total Expenditures in Average Non-Automotive Torts (Including Medical Liability Claims), 1985



Note: Percentages are based on the average of two estimates, and may not sum to 100 due to rounding.
Source: The RAND Corporation Institute for Civil Justice.

Appendix B

Growth of Medical Practice Cost Components from 1982 to 1989



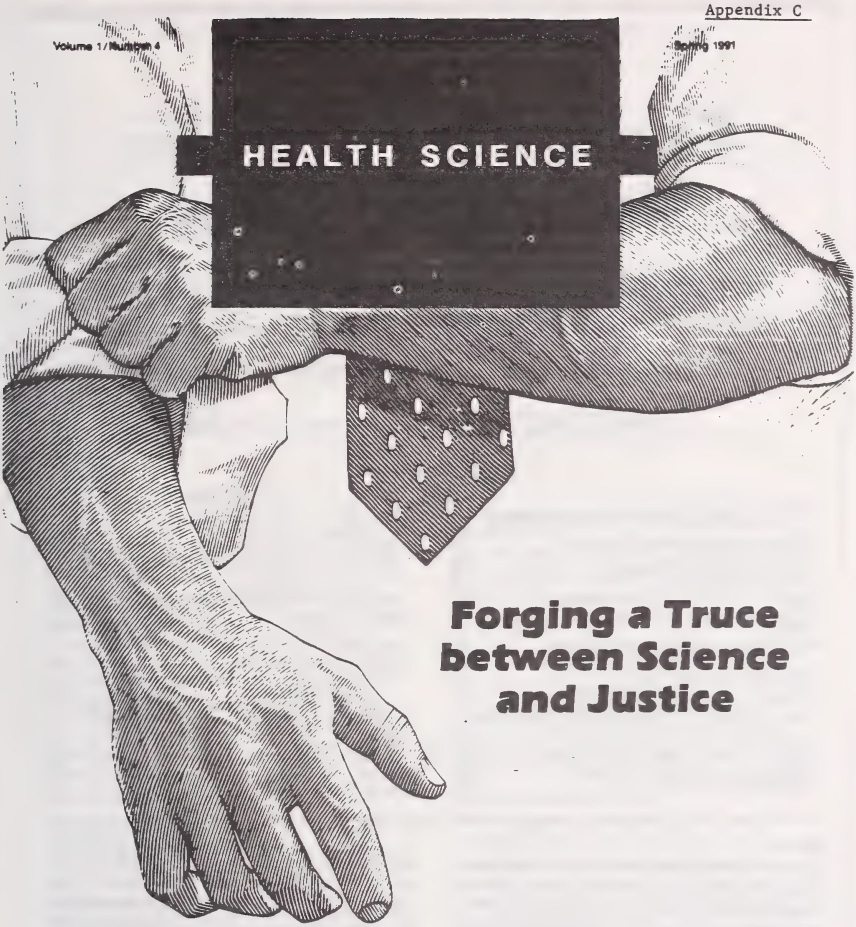
	Annual Percent Growth
Professional liability insurance premiums	15.1%
Medical supplies	12.2
Office expenses	9.4
Miscellaneous[1]	9.2
Nonphysician payroll	8.3
Physician payroll	7.2
Medical equipment	5.9

SOURCE: American Medical Association Socioeconomic Monitoring System, 1983 and 1989 core surveys. Data include self-employed nonfederal, nonresidence patient care physicians.

[1]Includes all items not included in other components.

Appendix C

Volume 1 / Number 4 Spring 1991



Forging a Truce between Science and Justice

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SPECIAL REPORT

Forging a Truce between Medicine and Justice

The Approach Presented by Organized Medicine's Administrative Alternative for Resolving Medical Liability Disputes

Franklin M. Zweig, Seymour Perry, and Sandra S. Thurston

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On Point

A new dispute resolution mechanism at the state level may be the only escape route from the intractable, no-win conflicts and polarization that now characterize the medical liability litigation system. The plaintiff's bar has much to offer in case finding and robust advocacy but is strapped by high transaction costs from representing small claimants, those who suffer injuries compensable in the $50,000 to $100,000 range. The defense bar wants to maintain the existing system for many reasons, among them the exercise of constitutionally guaranteed rights. The state medical boards appear to be hopelessly enmired; they show little ability to change, and they reduce public confidence in health care quality. The medical insurance industry has passed from commercial to doctor control; accompanying that passage is a nascent but unrealized merger of liability defense with health care quality improvement. Large-claim, meritorious cases may take, on average, 6 years to resolve, and patients and their families suffer the deprivation of both loss and costs until final judgment and award. The federal government has intervened with a claims clearinghouse, but is under shadow of impending conceptual and operational failure.

Organized medicine has proposed a new, cross-cutting administrative agency to reconcile these warring fragments and bring medical professional regulation under nonmedical control while streamlining adjudication, providing free claimant legal representation, and lowering its costs to the public. Georgetown's studies of the proposed legislation to enact a comprehensive, fault-based state agency conclude that a pilot test would be feasible. Orga-

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nized medicine, however, must go the extra mile to assure fairness to health care consumers. The agency will need the plaintiff's bar to operate a pilot test. And organized medicine must assume in a new fault-based, administrative agency responsibility for the standard of legal care as well as the standard of medical care. Absent a new institution, however, a truce between medicine and justice seems remote at best. It is in the interest of health care consumers to carefully experiment with such a public policy innovation.

Introduction: Organized Medicine's Alternative: Design and Summary Findings from Six Georgetown Mini-studies

In late 1987, the American Medical Association (AMA), along with 31 medical specialty societies (hereinafter termed "Organized Medicine"), proposed a comprehensive alternative to the existing malpractice litigation system that would substitute an administrative mechanism for determining liability and damages. The proposal was premised upon the medical profession's strongly held opinion that the current system was inherently unreliable and that tort reform efforts had failed to correct its shortcomings. Beyond injured patient compensation, the alternative would retain the fault concept and administratively link claims adjudication to more vigorous professional regulation. In May 1989, organized medicine published a final version of a model statute to implement the proposal.[1]

From the beginning, the proposal has been a target of comment and criticism, in part because of the magnitude of the suggested change. It represents a radical restructuring of the methods by which medical liability is determined.[2] Organized medicine recognizes these factors and proposes that one or more states implement its fault-based administrative alternative on an experimental basis. To date, several states have indicated serious interest, and the United States government has established new mechanisms to support such large-scale demonstration and evaluation efforts.[3]

It is difficult to predict how the overall system will operate in practice.[4, 5] Understandably, policy makers often can be reluctant to consider enacting a major institutional change since they do not know how it will work. At the same time, one cannot definitively determine its impact without implementation.

To assist such authorities, Georgetown University undertook a prospective analysis of the proposal. The analysis took the form of six mini-studies. Each mini-study, summarized in Table 1, inquired into an aspect of the proposed administrative alternative.

From the information pool generated by the mini-studies, we addressed several guiding questions posed at the study's outset: How fair is organized medicine's proposal when compared with the current judicial resolution of medical negligence suits? How comparatively efficient would it be in adjudicating claims by patients against physicians and other health care personnel? Would the administrative system cost more or less than operation of the courts with respect to medical liability actions? How well would the proposed administrative system utilize medical scientific information in claims resolution? To what extent does the workers' compensation scheme for adjudicating workplace injuries provide a useful model for organized medicine's proposal? What other practical and research issues unaddressed directly in our inquiry should policy makers consider?

This article reports our findings with respect to these questions. The study and the report, like all policy research, is burdened with important limitations.[6] It is intended, however, to contribute to the continuing debate on the merits as well as the feasibility of organized medicine's proposal for a new compensation and professional regulation institution at the state level. This report summarizes underlying assumptions concerning the existing litigation system that inform organized medicine's proposal. It details the proposal itself. It presents findings from the mini-studies that illuminate the proposal's plausible or possible impacts.

The mini-studies conducted to assess the proposal indicate that there is much to recommend it. While desirability and feasibility factors are not completely resolved, and additional inquiry is needed, we conclude that organized medicine's basic approach would be a significant contribution to thought and action in the medical tort field. Detailed in this report's last section, the fault-based, administrative alternative has significant merit, warranting implementation on an experimental basis.

At the same time, the model state legislation underpinning organized medicine's proposal requires amendments. Medicine must go the extra mile to assure perceptions of the proposed agency's fairness. Its fairness centerpiece is guaranteed claimant legal representation, but new standards are needed to implement the guarantees. Such standards are proposed in this article's last section. We also are concerned that the plaintiffs' bar must be brought into the picture, to assure both enactment and agency operational capacity. We strongly suggest that an experimental agency utilize employed counsel for one-half of its clients and the existing plaintiffs' bar for the other half. Equally strongly, we recommend that the proposal provide new incentives for plaintiffs' lawyers to find and bring claimants into the fault-based administrative system. Similar incentives should also be considered for bringing disciplinary proceedings against doctors.

Finally, we conclude from our search of the justice system literature that administrative adjudication could provide a fair and efficient forum for linking claims, medical professional discipline, and reform of rules guiding the tort system. While constitutional challenges are likely and have not effectively been addressed in this study, provision for factual review

Table 1

Focus and summary findings of mini-studies included in a prospective analysis of organized medicine's proposal for a fault-based administrative system to adjudicate medical liability claims and regulate professional practice

Study	Principal Focus	Main Findings
1. 4 contracted papers	General expert assessment and feasibility analysis from health policy, health economics, medical tort reform, and plaintiffs' counsel perspectives	From the writers' perspectives, the new agency should be implemented in a willing state. Plaintiff's position was the most negative, especially as concerns jury trial abolition, but concluded that small claimants could be served if administrative proceedings' quality were assured
2. Workers' compensation analogue study	Site visit/case study of the Wisconsin agency to determine applicability of claims adjudication and other features followed by a workshop at Georgetown University	Workers' compensation agencies present a useful analogue for the proposed medical agency, and its costs are in line with Georgetown's projected costs of the new agency. Workers' compensation in effective state government appears to be fair and efficient
3. Opinion surveys	600 judges and court-related personnel in several surveys on proposition to take medical dispute resolution out of courts and vest it in a workers' compensation-styled agency at the state level	Substantial minorities favored the proposition. Those favoring and expressing neutrality comprised the majority of respondents. Surprising flexibility toward the idea was observed, even among trial judges
4. Delphi survey	29 experts surveyed in a uniform paper-and-pencil questionnaire, followed by a 1-hour interview	A substantial majority judged the proposed new agency would bring efficiency gains and medical-scientific evidence improvements. A majority thought an agency would be less fair than the current system for medical malpractice litigation. Constitutional concerns were advanced by most experts, but a majority believed those concerns could be overcome through amendments to the proposal
5. Time/cost estimation study	Step-flow simulation of proposed administrative alternative with cost and time comparisons to the current litigation system	The new agency could cut adjudication time in half for resolution of typical claims and reduce it by 20% for profound injury. The public costs—between $2 and $7 million, approximately—would be substantially less than the current system's public costs while providing free claimant legal advocacy
6. Three state case studies	Assessment of tort reform experience of Michigan, Maryland, and Virginia medical tort reform for the administrative alternative	Maryland demonstrated that the new agency could be operated for the study's estimated costs and that medical professional regulation restructuring is desirable. Virginia demonstrated that case settlements were about the same in pretrial screening cases as other tort claims. Michigan showed that a medical tort reform mechanism—arbitration—could, after many years of litigation, pass constitutional muster, but that a voluntary alternative would likely be unused by health care consumers and providers

by an appellate court could strengthen organized medicine's proposal without damage to its central themes and major provisions.

Concerns about the Court-Based Tort System

Organized medicine's proposal is predicated upon a series of assumptions concerning the current litigation system's failure to fulfill the primary goals of tort law, namely: (1) providing compensation to injured patients efficiently and fairly; and (2) establishing appropriate levels of deterrence. These criticisms, while not universally shared, are supported by existing comments from knowledgeable observers.[7]

As noted by one observer of the malpractice system, "the most convincing case against traditional tort practice is that it fails miserably as a compensation

system."[8] With respect to the compensation function, organized medicine noted at the outset of its new institutional design that those suffering small or modest injuries are often precluded from pursuing their claims by the current system. In mid-1990, after the Georgetown assessment had been planned and launched, Harvard University's long-awaited study of New York hospital records was released. It supported earlier studies and long-held suspicions with harder data. The Harvard study concluded that only 1 in 8 of those suffering medical injury had filed claims, and that only 1 in 16 of those filing claims were compensated.[9] According to the U.S. General Accounting Office (GAO), "the need for the injured party to gain access to the system" is one of the primary failures of the tort system. The GAO study indicates that most lawyers will refuse to accept a malpractice case unless the expected recovery exceeds $50,000.[10] Another frequent criticism is that a relatively small proportion of insurance payments ever reach the injured patients, given the high cost of litigation.

Moreover, the awards that are made may not be equitable. Current evidence suggests that malpractice plaintiffs receive awards several times in excess of those received by other types of plaintiffs for the same injury. Even among malpractice plaintiffs, the awards received by plaintiffs with similar injuries vary widely. This unpredictability and lack of uniformity may result from the current system's reliance on the institution of the jury; the unregulated discovery by means of which both sides interpose delay and discovery as tactical ploys; and judicial failure to hold firm trial dates.

These tactical issues are galvanized by a substantive problem: given the disagreement that exists among experts as to the applicable standard of care in most malpractice cases, some observers believe it is not efficient or fair to entrust the outcomes to capricious lawyer negotiation, on the one hand, or to permit lay individuals to make such complex determinations, on the other.[11] By definition, each jury is inexperienced. The presentation of evidence must necessarily start at the basic level, which predictably lengthens the proceedings and causes problems of application of complex scientific information to the case before the jurors.

Some observers argue to the contrary. They point out that medical negligence cases are settled at the same high rate as most other tort cases—90 to 95%—and, therefore, never reach a jury. They argue that the verdicts are not capricious and that the much-discussed liability crisis is illusory or the short-term result of transitional adjustments of the health care and the legal care marketplaces.[12]

The current system also sustains criticism for its failure to provide appropriate signals to deter negligent conduct. Most medically negligent acts are ignored, sending a very inexact signal, one leading physicians to conclude that the system is essentially irrational. These factors appear to increase the prevalence of defensive medicine—medical care provided primarily to guard against future liability claims for less than perfect outcomes.[13]

Organized medicine's proposal is also premised upon the expense inherent in the current system. The transaction costs associated with malpractice litigation are high, both in monetary terms and in the emotional trauma associated with litigation experienced in common by medical professionals and their aggrieved patients. The adversarial process is fundamentally at odds with the cooperation between physicians and patients that is thought to be vital to the provision of quality medical care. The overall expense of litigation is necessarily reflected in high insurance rates and has contributed to the decline in availability of certain medical services.[14, 15] These criticisms collectively pressure for major changes in the current approach to medical negligence adjudication.[16, 17]

To be sure, 50 state legislatures have enacted a wide variety of procedural changes to address many of the problems noted above.[18] The procedural innovations range from required pre-litigation review of claims by pretrial "screening panels" to procedural fine-tuning such as shortening the statute of limitations. Despite over 15 years of procedural tinkering, organized medicine's position is that we still have a litigation system that is expensive, unpredictable, and ill-suited to the task.[19]

Others have recognized these problems and proposed substantive changes in malpractice law, including a number of "no-fault" proposals. No-fault systems offer broader coverage, and they could offer swifter payment, but they may also offer reduced compensation levels.[20]

From our study of the Wisconsin workers' compensation system, discussed later in more detail, Georgetown analysts found that administration of a fault-based agency would cost about the same as no-fault systems, and that the fault-based alternative could probably include free legal representation for claimants as well.

Some observers want to avoid fault-finding, because it requires extensive background information and expert reviews and results in medical professional stigma. To organized medicine, however, no-fault approaches "offend notions of justice and individual accountability by imposing liability on health care providers even when they have done everything humanly possible to treat a patient but were unable to prevent a bad outcome."[21] Moreover, organized medicine's legal leadership criticizes the no-fault approach for failing to serve the deterrence needs of the tort system, for treating malpractice and professional discipline in an unprincipled, unrelated manner, and for its economic infeasibility. Similarly, reliance on private contractual solutions are eschewed—the lack of equal bargaining power between patients and physicians invites additional litigation.[21]

Organized Medicine's Proposal

The AMA/Medical Specialty Society Liability Project, organized medicine's malpractice task force, proposed a complete restructuring of the process by which liability and damages are to be determined. It essentially maintains the current substantive rules defining liability. The following represents a brief synopsis of the salient features of organized medicine's plan.

The Medical Practices Review Board

The proposal establishes a state agency called the Medical Practices Review Board (the "Board") that would adjudicate medical malpractice disputes. In addition to determining malpractice claims, the Board would also handle all disciplinary actions against physicians, as well as serve as a clearinghouse for information concerning physician performance. The seven-person Board would be appointed by the governor and would be comprised of a four "lay" representatives and a minority of representatives from the medical and legal communities. Once constituted, the Board would appoint the agency's other key personnel, including hearing examiners, attorneys, claims reviewers, and investigators. Significantly, organized medicine recommended that the Board could be developed as an outgrowth of existing state disciplinary agencies. Those entities already possess some modicum of relevant medical expertise and would serve to ensure the close coordination of liability determinations and disciplinary actions.

The Claims Resolution Process

Under the proposal, all medical malpractice claims would be removed from the civil justice system and subjected to a closely defined set of alternative procedures administered under the Board's auspices. A fundamental purpose of this alternative is to provide injured patients with greater access to the legal process. This would be accomplished by permitting claims to be filed directly by the injured patient without the necessity of hiring an attorney. However, once established as a nonfrivolous claim, the claimant would be assigned a Board-appointed attorney for the duration of the proceeding.

The claims resolution function, which replaces the conventional jury trial scheme, is divided into four stages:

(1) Pre-hearing Stage. A patient who believes that he or she has suffered an injury caused by a health care provider's negligence could initiate a claim, without legal assistance, by completing a simple form describing the relevant circumstances, within 2 years of the date of injury for most claims. A claims reviewer employed by the agency would then evaluate each claim. A claims reviewer would examine the medical records and interview relevant parties, complete an analysis within 60 days of filing, and conclude that the claim has merit (and goes to the hearing stage) or lacks merit. If found to lack merit, the claim would be dismissed, with an explanation, pending an appeal to a single Board member, who would then conduct a de novo review to decide whether to affirm the dismissal or issue a recommendation that the claim be allowed to proceed. If the Board member concurred in the claims reviewer's recommendation to dismiss, the claimant could pursue the claim with privately retained counsel by submitting a supporting affidavit from an expert attesting that the patient's injury was caused by inadequate health care. Otherwise, the claim would be dismissed.

For those claims found to have merit at this initial stage, the claim would be forwarded to a private physician for review.[22] If this expert review concurred that the claim appeared to be meritorious, the Board would assign it to a hearing examiner. The hearing examiner, who need not be an attorney, would be a full-time Board employee. A major assumption is that examiners would develop, over time, special expertise in dealing with malpractice claims. The claim would also be assigned to a Board-employed attorney, who would represent the patient/claimant without charge. The patient would have the option to retain private counsel in lieu of the Board-appointed staff attorney. If the expert reviewer found that the claim lacked merit, the Board would retain the opinion of a second expert reviewer. If the second expert found merit, the claim would be assigned to a hearing examiner, and staff counsel would be appointed. If the reviewer concurred that there was no merit, the claim would be dismissed. While there is no provision for a claimant to appeal this dismissal to the Board, the patient could still pursue the claim with private counsel, as detailed above, by submitting a supporting affidavit from an expert health care provider.

(2) Hearing Stage. The hearing examiner assigned to the case would supervise all subsequent proceedings. The first, required event is the convening of a Pre-hearing Conference. In order to encourage settlement of claims, the proposal requires that blind settlement offers from the parties be made at this initial Conference. If no settlement is reached, the hearing examiner enters a pre-hearing discovery order limiting the time and scope of discovery. The Proposal provides that ordinarily each party would be limited to 30 interrogatories and three depositions, unless the hearing examiner ordered otherwise for good cause.

After discovery is completed, the proposal anticipates a final pre-hearing conference. Once again, blind offers must be made. Unlike the earlier offers, this round can trigger sanctions, including in the final award "compensation to the offeror of the offerors' costs, expenses, and attorneys fees incurred for all activities subsequent to the final prehearing conference." These sanctions are intended to ensure the seriousness of the settlement offers made at the final pre-hearing stage. If no settlement occurs, the parties proceed to a hearing.

An oral hearing would be held only if requested or

if the hearing examiner believes it would significantly aid in resolving the dispute. A hearing could function much like a conventional trial in that each side would be represented by counsel with evidence introduced by witnesses, subject to cross-examination. The hearing examiner is afforded somewhat greater authority in conducting the proceedings than a civil trial judge, as is befitting the administrative context. A hearing examiner, for example, can directly question witnesses and, if necessary, summon independent medical or legal experts for assistance in resolving contested medical or legal matters.

Following the hearing, the examiner is required to render a written decision explaining the basis for the result within 90 days. The decision will note whether the health care provider is liable for the plaintiff's injury and, if so, how much should be awarded in damages. It is anticipated that written decisions will develop greater consistency and reliability in the decision-making process. Over time, these decisions will create a body of precedent that will expedite settlement of meritorious claims by providing valuable reference points. Also, written decisions should provide for more reasoned damage awards, enhancing decision consistency and avoiding the risk, sometimes attributed to juries, of subjective awards based primarily upon sympathy for the plaintiff.

(3) Board Review Stage. In order to assure consistency every decision shall be reviewed by a panel of Board members, even if no party files a formal appeal or challenge to the decision. In those cases in which no appeal is filed, the Board may "adopt" the decision, at which time it is to be afforded precedential value. An adversely affected party may file a petition to review within 30 days of the hearing examiner's decision. The panel hearing the appeal must accept the facts as found by the hearing examiner if supported by substantial evidence; legal issues are subject to de novo review.

(4) Judicial Review of Board Decisions. Only limited judicial review of the Board's decisions would be permitted to the state's intermediate appellate court.[23] The only basis for appeal is narrowly limited to determinations of whether the Board acted capriciously or arbitrarily or otherwise abused its discretion.[24] The appellate court would have no authority to reexamine the facts, hear new arguments, set medical standards, or determine whether there was malpractice in the specific circumstances of the case. If the court concluded that the Board erred in following the stipulated procedures, the case would be remanded to the Board.

(5) Payment and Delay Prohibition. A physician found liable by the hearing examiner must pay damages within 30 days of the Board's decision. This rapid payment provision is based on the assumption that few decisions will be reversed by the courts. Moreover, by requiring payment before judicial appeal, the proposal eliminates any incentive to appeal as a means of delaying the obligation to satisfy the judgment.

Reform of Legal Rules and Liability Standards

In addition to restructuring the procedural mechanisms for resolving malpractice claims, organized medicine's proposal includes several modifications of the substantive rules affecting the assertion of malpractice claims. The most significant proposed changes include:

(1) Standard of Care. The standard currently applied in most states is based upon customs recognized and practiced in the local community by what similar health care providers customarily do in similar situations.[25] Under the fault-based, administrative proposal, the Board would apply an alternative standard, focusing on whether the challenged actions fell within the "range of reasonableness," to be determined by reference to the standards of a prudent and competent practitioner in the same or similar circumstances.[26] This formulation recognizes that a broad spectrum of medical care is reasonable and should not result in the imposition of liability, it permits health care providers to employ a course of treatment that is recognized as appropriate by a respectable minority of their colleagues. At the same time, this standard frustrates striving toward a national standard of care. Statewide and nationwide care standards underpin the movement to forge medical practice guidelines. Such guidelines, whether official or voluntary, could raise health care quality, lower cost, and provide safe harbors against malpractice charges. Since organized medicine's alternative has been drafted for the states, each state may wish to craft its care standards based upon such considerations.

(2) Causation. The causation standard for determining liability is significantly modified. In many states, when more than one possible cause of the patient's injury exists, recovery is denied unless the health care provider was more than 50% responsible for the patient's loss.[27] Under the proposed standard, recovery is permitted if the provider's negligence is merely a "contributing factor" in causing the injury. The conduct is deemed a contributing factor if it substantially increased the risk of an injury and such injury in fact occurred. Damages would be apportioned according to the physician's degree of fault under a purely comparative responsibility standard. The long-standing rule of joint and several liability would be abolished.

By making providers liable for damages in proportion to their actual responsibility, the suggested standard is more generous to patients than the current law applied in most jurisdictions, since it allows recovery even if causes aside from the physician's negligence are responsible for more than 50% of the injury. At the same time, the "contributing factor" standard is arguably fairer to health care professionals by recognizing the role of preexisting conditions in otherwise negligently caused injuries. It reflects the uncertainty inherent in the practice of medicine and avoids the arbitrariness of cutting off all recovery at a fixed rate of causation.

(3) Informed Consent. The proposed alternative adopts the current minority rule for informed consent. The minority rule evaluates the adequacy of disclosure of information in obtaining consent from the reasonable patient's perspective, rather than the health care provider's perspective. Proponents argue that the reasonable patient standard is fairer to patients, will facilitate greater communication between the patient and health care provider, and will lead to better shared decision making, which may help to reduce the incidence of malpractice. Opponents argue that this feature reduces the fault concept's robustness and provides a safe harbor from liability in the absence of practice guidelines.

(4) Damages. The proposal also urges certain changes in the law of damages. Economic damages will continue to restore injured patients to the position they occupied "but for" their injuries. The proposal provides that specific guidelines would be developed through rule making for the different components of economic damages, including interest rates, work and life expectancy, and the costs of medical, rehabilitative, custodial, housekeeping, and child care services. Hearing examiners would assure greater consistency and predictability by making specific awards for each item of requested damages. In addition, any award of future damages in excess of $250,000 would be paid in accordance with a periodic payment schedule. In general, damage awards would be reduced by collateral source payments, those costs recouped through insurance and lost work payments.

The Model Act also would define and limit non-economic damages. Such damages would be capped at an amount ranging from $150,000 to $700,000, depending upon the life expectancy of the patient prior to the injury. The cap is defined as an amount equal to one-half of the average annual wage in the state multiplied by the claimant's life expectancy. The cap is justified, in part, because of the free legal representation feature for meritorious claims; there is no need for an award of non-economic damages to cover the plaintiff's attorney's fees.

Strengthened Professional Regulation

In addition to its procedural reform and substantive law changes, the fault-based, administrative proposal is also designed to strengthen the process for credentialing and disciplining physicians. It sides with the growing critical chorus charging state medical boards with ineffective and self-serving conduct.[28] It provides an elaborate process, including emergency procedures, for disciplining and suspending incompetent or dangerous physicians.

Additional, more general, efforts are intended to reduce frequency of negligent acts through mandatory participation in continuing medical education and in quality assurance/risk management programs. Under the proposal, the Board would create and maintain a clearinghouse for reports from hospitals, insurers, courts, and physicians. The clearinghouse would receive reports of any settlements or awards made in the claims resolution and any notifications of disciplinary actions taken by other states. Information collected under this proposal may overlap with the reporting already provided for under current federal law.[29]

To promote review of physicians' practices, the proposal includes several types of reporting requirements. These include mandatory biannual hospital review of physician performance in connection with staff privileges and information provision regarding substandard performance. Physicians are required to have adequate insurance coverage or, alternatively, they will have to document the availability of assets that could be used to satisfy an adverse medical liability judgment. Courts in the states are required to report any criminal convictions of physicians. Physicians not otherwise affiliated with an institution that conducts the required biannual credentialing review are required to report directly to the Medical Practices Review Board.

Summary

In a bold sweep of procedural reforms, paid and guaranteed claimant legal representation, substantive law codification, and practice oversight, the proposed administrative alternative promises advantages for health care consumers injured in the course of diagnosis or treatment. At the same time, it would abolish medical negligence as a cause of action and would disable the common law courts from adjudicating such disputes. Policy makers should carefully weigh the trades involved. As our mini-studies suggest, the quid pro quo for the parties appears to be substantial. The tradeoff between use of the jury system and greater access to the legal system and realization of faster compensation is worthy of serious consideration in general. The alternative system is sufficiently thought through to permit a principled, well-evaluated, pilot operation of the administrative alternative.

Papers Contracted with Experts: First Mini-study

The first mini-study conducted at Georgetown University was a collection of four papers contracted with medical malpractice experts reasonably expected to articulate their analyses within a defined sector of the health care community. Randall Bovbjerg, Esq., Urban Institute, was selected to portray consumer interests and insurance considerations within a health policy analyst's perspective. Mary Ann Baily, Ph.D., George Washington University, was asked to assess organized medicine's proposal from the health care economist's perspective. Laura L. Morlock, Ph.D., University of Maryland, was chosen to evaluate the proposal from a medical tort reform perspective. J. Douglas Peters, managing partner in a Detroit, Mich-

igan, law firm, assessed the proposal from the plaintiffs' counsel perspective.

While they were asked to comment on specific issues such as the administrative, fault-based system's fairness and feasibility, the writers were given wide latitude to analyze all of the proposal's features. Each writer found things to admire and reject in the proposal. More important, they independently agreed that the fault-based administrative alternative should be demonstrated in practice.[30]

Health Policy Analysis Perspective: Bovjberg

Bovbjerg placed organized medicine's proposal in a policy reform perspective. A torrent of mid-1970s and mid-1980s changes had been "less of the same," meaning that pro-plaintiff changes accomplished by judicial decision or societal change were rolled back by tort reform. Many states' reforms involved "take-away" proposals that pitted the medical establishment against plaintiffs' attorneys. Despite the seriousness of the malpractice issues, the debate was seldom focused on how to improve the functioning of the tort system.

The fault-based administrative proposal is notable in that it represents a major tort reform contribution. Its comprehensive approach transcends the prior "take-away" mentality; it represents a "major advance" over organized medicine's previous negativism. Rather than being driven by a crisis mentality, the integrated scheme focuses on the problems of civil justice, questions of access to justice, and fairness of results.

Bovbjerg questioned whether the proposal's underpinning critique of the current civil justice system is persuasive. Some criticisms were indeed well-founded. The author cited strong evidence that the current system had failed in its goal of compensating those injured by medical negligence. Current methods for ascertaining damages are inadequate; damages law is quite flexible, and inconsistency among cases results. Bovbjerg generally expressed support for the organized medicine's legal reforms, noting that the proposals were sensible extensions of existing legal trends with respect to the standard of care, the law of damages, and informed consent.

Other criticisms of the judicial system, Bovbjerg emphasized, could not be proven. He questioned whether the proposal had met its burden of showing that the problems with litigating malpractice cases were any more serious than such problems in other litigation contexts so as to justify such special treatment. The proposal's negligence deterrence provisions were less clear; little was known about the relationship between malpractice and deterrence. The proposal's assumptions as to the incompetence of juries, however, could not be directly proven. One can speculate that jurors are biased in favor of plaintiffs, but proof is lacking. While it is difficult to believe that the current system is optimal, many believe that jurors are capable, in most cases, of understanding the issues presented, even if significant time (and hence expense) are required to educate them. More importantly, the relevant question is not simply whether juries are competent, but whether the entire litigation system—which includes the roles played by liability adjusters and attorneys who resolve many cases through settlement—is competent.

While litigation screening panels had promised procedural improvements, they failed to demonstrate them. New, proactive methods are needed to identify claimants. Bovbjerg's primary concern was his "nagging fear" that the administrative system would be predisposed to defendants, owing to the nature of the Board's structure. Questions of the proposal's political feasibility and its constitutional validity turn on its perceived fairness; it cannot appear that the medical profession has "captured" the dispute resolution process. The ultimate question is whether this approach would be perceived as more pro-defendant than the current system. On the other hand, organized medicine deserves a chance to demonstrate its commitment to even-handedness.

Health Law Economics Perspective: Baily

After acknowledging many of current medical negligence dispute system's failures, Baily observed that, in light of so many faults, even a "very flawed alternative could be superior"; the question may not be whether organized medicine's plan is "right," but simply whether it is "better." While answering this limited question was difficult, Baily noted that the proposal had three major potential strengths. First, it would likely result in improvements in enunciating the legal standard of care. Since the medical profession establishes the actual standard of care through its delivery of medical services, it was fully appropriate that the medical community have a more substantial say in the articulation of its legal standard. This was especially true given the imprecision of the current method for ascertaining the applicable standard. While juries may well do their best, the occasional aberrant result can send strong shock waves through the medical community.

Baily predicted that the proposal would improve the tort system's deterrence function. By providing an inexpensive screening mechanism for those suspecting malpractice, the plan should have the positive effect of uncovering previously undetected acts of negligence, especially where the damages were modest. Similarly, specialization of the decision making function almost certainly would promote consistency, particularly with respect to the determination of compensation levels, which appear quite arbitrary at present. This, in turn, could promote the deterrence function.

A third, positive feature is the structured linkage between claims adjudication and quality assurance. Malpractice can fall on a continuum ranging from deliberate error (owing to personal gain or substance abuse) to isolated mistakes. Many of the errors in the middle range stem from careless habits, lack of knowl-

edge, or inadequate skills that could perhaps have been avoided. The proposal deals with the source of the problem through better disciplinary controls and quality assurance programs; it represents a welcome shift in emphasis. Baily observed that attaining a system that considers standard of care issues in light of cost considerations would be a major achievement.

Baily's concerns are straightforward, directed largely to managerial issues. The Medical Practices Review Board's actual implementation almost certainly would be affected by unanticipated impacts. She questioned how the Board's operations could be financed: costs could exceed those of the current system; plaintiffs' attorneys claims screening functions would become a responsibility of the state; an underfunded demonstration would create an unrecoupable credibility loss for the administrative alternative.

Given the Board's structure, Baily worried, there was a risk that a small group of individuals—consisting primarily of the Board members—would control the determination of the applicable standard of care. While many cases are easy to resolve, others present difficult standard of care questions. On the other hand, Baily concluded, the Board's expertise and involvement with quality assurance programs was more likely to "facilitate orderly evolution of the standard of care, so that sensible cost-benefit tradeoffs can be made without fear of litigation." While fault-based systems overemphasize negligence and underestimate adverse outcomes, the fault-based system provides better deterrence than a no-fault system. On balance, Baily welcomed the possibility of the proposal's demonstration.

Medical Tort Reform Perspective: Morlock

Morlock's analysis was based in large part on a comparison of organized medicine's proposal with Maryland's experience instituting a pretrial screening agency. Under the Maryland approach, virtually all medical malpractice claims are submitted to a three-arbitrator panel that addresses both liability and damages. While litigants have a right to return to court and a "normal" trial, there is a presumption that the panel decision is correct. Initial concerns about pro-defendant determinations and large increases in the number of claims filed were unrealized.

In the first 8 years of the program, slightly over 2,200 claims were filed. Only some of the claims resulted in actual hearings; about 50% of the claims were closed without a formal filing with the administrative agency responsible for handling the arbitrations. Of those claims filed with the agency, a large majority settled or were dismissed prior to the hearing. In the remaining cases that went to hearing, the plaintiff prevailed in 40% of the cases. Compared with plaintiff prevalence rates, estimated by the U.S. General Accounting Office at 22%, Morlock concluded that there was no evidence of pro-defendant bias in the Maryland experience, despite the fact that doctors were regularly employed on the panels as decision makers.

Moreover, the pretrial arbitration experience in Maryland was apparently efficient in that it reduced the number of disputes requiring formal adjudication and decreased the average disposition time. Only 2.3% of all claims proceeded to formal trial, about one-half the national average. Similarly, disposition times in Maryland were less than the national average.

These findings favor predictions that organized medicine's alternative can be achieved through an administrative structure. Maryland's system did not cause a flood of claims, nor did it apparently work to deprive meritorious plaintiffs of a recovery. Without evidence of a pro-doctor bias in Maryland's scheme, Morlock stated that the fault-based administrative proposal offered the potential for improving patient access to the system, expecially if it were well publicized.

Two changes would predictably serve to increase the proportion of claims that resulted in an award of compensation: (1) shorter stature of limitations periods would reduce "evidentiary decay" of the case; and (2) availability of an "experienced attorney at no cost" should increase the porportion of successful claims. This prediction could well be a dominant one: in the 2,217 claims filed with the Maryland administrative agency, a total of 1,169 different claimants' attorneys were involved. The experience level of the attorney was "among the strongest predictors of how the claim was resolved: more experienced attorneys were more likely to settle prior to a formal hearing or to resolve the case at a hearing." Morlock also noted serious concern with the recent changes in the Maryland rules. In 1986, the state law was changed to require claimants to present a certificate of merit, and it also imposed a $350,000 cap on non-economic damages. These changes may have triggered an observed 36% claims reduction.

Based upon the Maryland experience, Morlock expected that the administrative alternative—assuming competent implementation—could serve to increase predictability and promote earlier settlement. The key issue for effective implementation is the Board's "degree of success in attracting sufficient resources and well qualified personnel." As suggested by others, serious constitutional challenges would almost certainly be raised. Given the perceived utility of the Maryland experience, the writer suggested that the proposal's sponsors consider an amendment making the proposal nonbinding as a means of escaping constitutional and political distractions.

Morlock concluded that organized medicine's approach to integrating malpractice and disciplinary systems was "potentially a powerful strategy for addressing many of the current problems with physician oversight as performed by state medical boards." Moreover, there was reason to believe that the linkage could be made. Disciplinary effects would not have to

await resolution of a negligence dispute—as is now currently the norm—but could begin while the current litigation was still pending. The potential for developing more detailed information on outcomes to identify suboptimal procedures—in addition to the traditional justification of ferreting out the few "bad apple" doctors—is a major advantage.

Plaintiffs' Counsel Perspective: Peters

Analysis of organized medicine's proposal must take cognizance of the views of the plaintiffs' bar, given their direct stake in the current system and also their role as a proxy for the interest of the general public. While Peters judged that adoption of the administrative alternative did not serve those interests, he did recommend that it be tested on a small scale and that it be directed to stimulate claims from people alleging smaller damages.

Indeed, Peter's analysis was more than critical; he judged that the plan was fundamentally unconstitutional, unfair, and unsound. The proposal, he wrote, "sidesteps hundreds of years of Anglo-American justice" from Magna Carta to Constitution to common law. Peters admitted that the system as presently constituted was far from perfect, noting that it "provides excellent compensation for big injuries, poor or no compensation for small injuries, and no compensation for those who do not realize they have a claim."

Aside from matters concerning dispute resolution policy, Peters' most defined criticism concerned the institutional incompetence of administrative agencies. This criticism stemmed from several observations. First, little in the history of medical disciplinary agencies suggested any ability to perform the tasks to be assigned under the Model Act's provisions. These are the same agencies that were "chronically underfunded, understaffed, [and] undermotivated in their task of tackling physician discipline." Second, managerial obstacles were pervasive: if claims were added involving issues often more complex than competency issues, the Board's performance could only deteriorate.

Serious questions were also raised about staffing the Board. If an anticipated, desired increase in claims were realized, would the Board conceivably have enough attorneys and hearing officers to handle the increased number? Would the staff attorneys be provided sufficient funds to retain competent experts? Would they have time to do the necessary research?

Given the proposed, arbitrarily shortened limitations on discovery, the author suggested that the quality of representation almost certainly would be lower than currently observed. This would likely create unfairness.

As one example of unfairness built into the Medical Practices Review Board's Model Act, Board attorneys are apparently limited to using in-state experts while defendants remain free to retain any expert. Given the likely difficulty of obtaining in-state experts to testify against their friends and colleagues, these equitable concerns are great.

Finally, Peters questioned the ability of state-employed hearing officers as well as their potential lack of independence. While law firms have the option of increasing or decreasing their resources depending on the number of cases they have, Peters noted, the Board would not have that flexibility, given the constraints of government shortages and budgetary dictates. Such inflexibility could lead to a diminished work product or chronically overburdened staff.

> "In sum, the act's design is fatally flawed and probably irreparable. To emulate or build on the crumbling foundation of state medical boards; to create a closed economic funding system; to create built-in conflicts of interest between act lawyers and claimants; to give boards the power to enact rules and regulations and define standards of care which are beyond appellate review; to fail to provide a basis for determining staffing levels. . ." [will assure the Board's failure].

Georgetown's Findings: Contract Paper Implications and Five Additional Mini-studies

Contract Papers' Cross-Cutting Implications

Peters' critique and the other writers' analyses contributed, in part, to an analytic scheme for the empirical and secondary studies Georgetown deployed in its efforts to provide an even-handed, if prospective, assessment of organized medicine's alternative. Peters' analysis implies an irremediable, economically powered, professional state-of-war among physicians, attorneys, and patients. The only people not organized to play these war games, Peters and the others agree, are the small claimants whose injuries attract little interest from other players. Harvard's data from New York hospital records suggest that small claimants lack access to the legal game. As a group, they seem to be older and lower income people.

Peters and the other three contracted analysts agree on one additional theme: empowerment of the small claimant is desirable, and organized medicine's proposal for a fault-based administrative agency could open windows of access opportunity for such empowerment. But with such high stakes already implanted in a working-but-unsatisfactory, socially costly, medical negligence system, some observers believe that the uncertainty created by a new institution would fuel conflict unless the actors in the current system are provided a stake in charting a new one.

Others regard such a view as a self-fulfilling prophecy, antithetical to rational thought. If an agency such as the administrative alternative were to bring peace and cooperation to patient-physician relations, with the assistance of legal services, through objectively and perceivedly fair procedures and standards, this view holds, the public interest surely would be served.

Georgetown's six mini-studies imply that the ad-

ministrative alternative could be crafted to satisfy both views—the war game view and the rationalistic, health policy view. It is not necessary to make a choice between one and the other. While such accommodation may be difficult to achieve, and while a truce between medicine and science may take some time to gel, we conclude that the goals are achievable within the general design offered in organized medicine's administrative, fault-based proposal. To lay a foundation for this theme, we summarize here our ministudies' findings. In this article's last section, we extrapolate from those findings the modifications needed in organized medicine's Model Act to accommodate both the war game and the rationalistic perspectives.

Findings from the Five Additional Mini-studies

- The administrative alternative is designed to borrow from the best practices and procedures of the workers' compensation systems in Georgetown's study of such an expert agency.
- The administrative alternative can feasibly be adapted from the workers' compensation experience of good government states such as Wisconsin.
- Both the Wisconsin Division of Workers' Compensation and an opportunistic review of the Wisconsin Securities Commission disclose that claims adjudication and professional discipline can be housed in the same agency. Moreover, our reviews of financing methods of Maryland's Health Care Arbitration Office and the State Medical Board—fortified by recent data issued by the Inspector General's Office of the Department of Health and Human Services and the Federation of State Medical Boards—suggest that a proposed Medical Practices Review Board can feasibly be financed.
- Judges and court-related personnel evidenced unexpected flexibility in roughly equal divisions of those who favored vesting medical claims disputes in such an expert agency, those opposed to such a change, and those who were neutral and might move toward or away from such a proposal.
- Majorities of 29 experts closely surveyed in a Delphi study judged the proposal to improve efficiency of claims resolution and improve use of medical scientific information; a majority judged the proposal not to be as fair as the current system, although a substantial minority believed an administrative system to be equally or more fair.
- The administrative alternative would save up to 50% of time in dispute resolution from claims filing to compensation and could cost the public significantly less to operate the agency than judicial system costs.
- While political and constitutional questions are yet unsettled, such obstacles, from information gleaned in the states studied, might be overcome, with a few modifications, through amendments to the proposed agency's centerpiece—free, guaranteed legal representation for claimants.

In sum, Georgetown's study staff concludes that the proposed agency could be positioned to address the most important deficiencies resident in the current civil resolution of medical negligence disputes. The workers' compensation model provides a useful template, one that likely would be cost-effective. The provision of paid legal counsel would be a major step forward in patient empowerment at an affordable price level, especially in light of the public costs of running the courts. To be sure, two important issues lay outside our study's boundaries—the fiscal impact of small claims increase heralded by the Harvard study reported midway through the Georgetown effort, and a thorough constitutional analysis of the administrative alternative. Such issues should be answered in service to strategic operational planning of the proposed agency's implementation. However, the information currently available strongly suggests that the administrative alternative could function successfully in a state committed to its goals and a careful demonstration of their implementation. It is possible that a first demonstration would be very successful, in part owing to the failure avoidance activities its sponsors would take in the sunshine of continuous national attention.

Predictions That Must Await a Pilot Test

In support of its proposal, organized medicine made a number of assertions as to the plan's impact, if implemented. These predictions included: (1) an increase in the number of claims filed and of claimants receiving a recovery, since compensation would no longer be limited to the small percentage of patients whose damages were sufficiently large to attract private attorneys; (2) better differentiation between meritorious and nonmeritorious claims; and (3) improved procedural efficiency owing to the expertise of the decision makers. The question remains as to whether these predictions would in fact be realized. They can, however, be posed as high priority research issues and be built into a demonstration project's evaluation package. Such net impact research would help find definitive answers to questions that have long plagued the present system as well.

Similar working hypotheses can be generated for other predictions advanced by organized medicine or any of the authorities enlisted to help Georgetown's study. A strategic plan and a research strategy could be developed for: incentives to attain physician participation in state-sponsored credentialing reviews; efforts to attain physicians' reports of suspected incompetence, impairment, and drug or alcohol dependence among their colleagues; or Medical Practices Review Board staffing patterns to investigate substandard

performance based upon information contained in the various reports mentioned above or as filed by members of the public.

Weaknesses in the Proposed Scheme

While a test of the Medical Practices Review Board would thus be very useful to governments and professional associations, promotion of a research agenda is not the equivalent of saying that the Georgetown review found no defects in and revealed no cautions about organized medicine's model. Discussed at greater length in this article's last section, the Board impliedly sets legal services standards, but the Model Act articulates none. Furthermore, while incentives for participation of the plaintiffs' bar are not ruled out by the Model Act, neither are they addressed in organized medicine's proposal.

Furthermore, restructuring of the reporting relationships between the proposed agency's executive management and its claimant-serving legal staff is absolutely essential to retain health consumers' confidence in the agency's fairness. Legal help should be available initially (prior to claims filing) and continually to claimants, not predicated upon a claims examiner's certificate of merit.

Public sensitization to the agency's availability requires enhanced agency visibility and avoidance of some medical boards' virtual invisibility. If the new institution is dedicated to a more open, more effective system of medical professional regulation, provisions to that end may best be written in the Board's authorizing legislation and not delegated to later rule making.

One important issue may have practical as well as constitutional implications for the proposed Board's fate: the way the Model Act carves out administrative jurisdiction for direct health care providers—physicians, hospitals, nurses, technicians, for example—but leaves indirect health care providers—druggists, pharmaceutical companies, medical device manufacturers, independent testing laboratories, for example—in the current litigation system. The practical issue is a possible "procedural nightmare," identified by judicial members of Georgetown's advisory committee and published in *Courts, Health Science & the Law, 1*, at 48. A mandatory administrative system for adjudication of claims could include "any act incident to or arising out from a health care provider/health care consumer transaction alleged to have led to a patient's injury." Not only would such authority likely avoid fragmentation of dispute resolution, but it could address equal protection of the law issues that some Delphi survey experts identified as potential constitutional challenges to the Model Act.

Other, arguably less urgent, issues could be addressed as well. A public advisory commission should be considered as the proposed Medical Practices Review Board's public reporting authority. And a major, expert-based consensus effort to resolve constitutional issues would prove helpful. But these are adjustments to an institutional design that holds promise to reach a truce between warring factions in the medical liability field. They are refinements of a proposed system that seeks to rationalize medical injury compensation, promote medical professional discipline, empower people who now, by circumstance or choice, are alienated from the legal system. Such adjustments and refinements have been drawn, in part, from the contract writers' comments, summarized above, and five additional mini-studies, described below.

Case Study of a "Best Practices" Workers' Compensation Agency

Summary and Conclusions. Georgetown concludes that a workers' compensation agency model is an apt analogue for organized medicine's proposed Medical Practices Review Board. The plan for such a Board closely parallels the actual structure and function of at least one operating workers' compensation agency, the Wisconsin Division of Workers' Compensation. We conclude from our empirical study of the Wisconsin agency, moreover, that an expert agency can operate fairly, efficiently, and professionally and be perceived to do so. It is possible to avoid the specter of red tape, callous disinterest, perennially starved state budgets, and demoralized state employees attributed by some as the inevitable fate of an administratively adjudicated medical claims system. The similar size, claims-processing capabilities, and budget of the Wisconsin agency suggest that the proposed Medical Practices Review Board could be an organizationally feasible entity.

A case study was conducted in the State of Wisconsin, together with workshop to deliberate its results. Organized medicine's proposal had been discussed, although not documented, as an expert agency in the nature of workers' compensation agencies. Since many states were reconsidering their workers' compensation schemes, Georgetown consulted the literature and expert opinion to find an agency thought to operationalize best bureaucratic practices. Wisconsin was selected, and the Wisconsin Division of Workers' Compensation was studied on-site. To what extent were workers' injury claims fairly and efficiently dealt with? To what extent could the workers' compensation agency be used as a prototype for the Medical Practices Review Board proposed by organized medicine? What implications might stem from the fact that the workers' compensation system is based on no-fault principles while organized medicine's proposal is fault-based? Serendipitously, another model surfaced in Wisconsin—the state's Securities Commission, self-financed and complete with licensure and claims authority under one administrative roof. How, we asked, could the Commission's experience illuminate the claims regulation connection built into the proposed medical practice scheme?

Georgetown's study team, headed by attorney Sandra S. Thurston, read everything available about

the Wisconsin agency and then visited the state. Interviews were conducted with officials inside the Division of Workers' Compensation, counsel representing claimants and employer-defendents, academic evaluators, and former administrative law judges.[31] A draft report was then circulated to the people interviewed, and comments were collected. A formal report was written, herein summarized. That report provided the discussion foundation for Georgetown's workshop on the workers' compensation analogue conducted May 29, 1990.[32]

Because organized medicine sought to link claims adjudication and professional regulation, Georgetown conducted another Wisconsin case study: the Wisconsin Securities Commission. The Commission is an expert agency that adjudicates claims and regulates the professions involved in securities underwriting. How, we asked the Wisconsin Securities Commission, can both functions effectively be linked?

We found in Wisconsin's administrative practice a qualified no-fault system, as discussed below. This is a middle zone between fault and strict no-fault. Worth considering for administrative dispute resolution alternatives, many Wisconsin Workers' Compensation Division features illuminate prospects for the proposed Medical Practices Review Board.

Claimants retain private counsel to represent them in workers' compensation proceedings. Attorneys are compensated through a contingent fee agreement with claimants. Workers' compensation representation frequently is a specialized law practice. Under Wisconsin Administrative Code provision Ind 80.43, claimants' attorneys can receive a maximum fee of 20% of the amount awarded in compensation to their clients. An attorney can charge less than the 20% contingent fee if he or she feels it appropriate; however, the entire 20% fee is routinely approved.

People interviewed for this case study judged there to be no shortage of claimants' representation. A specialized workers' compensation bar has developed. While some informants felt that in some cases the 20% contingent fee was too high, others felt it struck a proper balance between sufficient incentive for lawyer representation, on the one hand, and sufficient realization of injured workers' compensation, on the other.

Approximately 1.9 million people, working for 120,000 insured employers and 150 self-insured employers, are currently protected by the Wisconsin program. This amounts to more than 90% of Wisconsin workers.

Approximately 77,000 claims, 5,400 requests for hearings, and 1,700 actual hearings were processed in 1989. Nearly a 17% increase in claims volume occurred between 1985 and 1989 (Table 2).

Annual Hearings Applications. Most claims are resolved without a hearing. The hearing procedure is described below. Unsatisfied claimants or unresolvable claims may be heard by an administrative law judge (ALJ). Table 3 describes the Division's recent hearings application history.

Actual Hearings. Approximately two-thirds of claimants settle before their hearing is held. In 1988, 1,676 hearings were held. This is 32.6% of 5,141 applications for hearing filed.

Appeals from Hearings. If a claimant is dissatisfied with a hearing's results, the workers' compensation law in Wisconsin provides for four levels of appeal. The first appeal is filed with the Labor and Industry Review Commission, the second appeal in circuit Court, the third appeal in the Court of Appeals, and the final appeal in the Wisconsin Supreme Court. Each appellate level is empowered to affirm the lower ruling, modify an award, or remand for further proceedings.

The labor and Industry Review Commission is separate from the Workers' Compensation Division and handles workers' compensation appeals, unemployment appeals, and fair employment appeals. The Commission is governed by three commissioners appointed by the Governor for 6-year staggered terms. Commissioners are not necessarily lawyers, and their

Table 2

Five-year claims volume in the Wisconsin Workers' Compensation Division, 1985–1989ª

Year	No. of Workers' Compensation Claims Filed
1985	66.235
1986	66.059
1987	68.369
1988	76.917
1989	77.391

ª Source: Georgetown University Program on Science and Law from data furnished by the Workers' Compensation Division, Wisconsin Department of Industry, Labor and Human Relations.

Table 3

Hearings applications requested by claimants by number and by percentage of applications of total claims filed in the Wisconsin Workers' Compensation Division, 1985–1989ª

Year	No. of Hearings Applications Filed	% of Workers' Compensation Claims Filed
1985	5.173	7.81
1986	5.443	8.24
1987	5.561	8.15
1988	5.153	6.70
1989	5.410	6.99

ª Source: Georgetown University Program on Science and Law from data furnished by the Workers' Compensation Division, Wisconsin Department of Industry, Labor and Human Relations.

salaries are approximately $60,000 a year. They have the authority to affirm, reverse, set aside the findings in whole or in part, or direct the taking of additional evidence. Normally, cases are not remanded to another hearing because the Commission's policy is to encourage complete hearings the first time around.

Table 4 illustrates the policy's impact. Information describing claimants' opinions about the appeals process is not available. Attorneys interviewed judged the process to be fair and evenhanded.

Injury, Qualified No-Fault Mechanisms, and Premium Rates. The Wisconsin workers' compensation law defines an injury as any mental or physical harm due to workplace accidents or disease, including accidental damage to artificial limbs, dental appliances, and teeth.

Because workers' compensation is a "no-fault" system, compensation generally must be paid even if the injury was the employee's fault. In Wisconsin, the no-fault conception is qualified: compensation may be increased by up to 15% if the employer fails to comply with a safety rule or decreased by 15% if an employee fails to comply with a safety rule.

Premium rates for employers are established by the Commissioner of Insurance through the Wisconsin Compensation Rating Bureau. Rates vary, depending on the industry or business type and the kind of work performed. Eight hundred different rate classifications are presently established. Rates in each category depend on previous injury experience. Thus, some incentive exists for employers to maintain a safe workplace. If an employee of an uninsured corporation is injured, the officers of the corporation are personally liable for the payments. It is a misdemeanor for an employer not to secure workers' compensation insurance, which is required by law.

Filing a Claim. Injured workers are encouraged to report an accident or ailment immediately to their supervisor and to seek first aid and medical attention without delay. Notice of an injury or disease should be given to the employer within 30 days.

Claims are barred if not filed within 2 years from the date the employee or his or her dependent knew, or ought to have known, the nature of the injury or disability and its relation to employment. The right to compensation is not barred if the employer knew of the injury upon which that late claim is based. The statute of limitations for these claims is 12 years.

When the employer has notice of employee injury, he or she is then required to report it to the insurance company (or to an internal claims office in self-insurance situations). Simultaneously, an "Employer's First Report of Injury or Disease" must be filed with the Workers' Compensation Division.

If an injured worker misses more than 3 days of work and is found eligible, that worker will receive compensation for lost wages. The employer or insurer is required to send the Workers' Compensation Division a follow-up report within 14 days showing that payment of benefits has begun, or presenting reasons for denial of benefits.

Medical expenses are paid in full, and the worker has the choice of any physician, chiropractor, osteopath, dentist, or podiatrist licensed in the state. Workers have the right to every type of treatment which is "reasonable and necessary to cure" as ordered by the treating doctor.

Injury Classifications. Work-related injuries are allocated into four classifications: temporary total disability; temporary partial disability; permanent partial disability; and permanent total disability. While specific injury classes qualify workers for compensation ranges, they could qualify patients for such ranges and for priority in the dispute resolution process. Organized medicine's scheme has not done so. Neither has its Medical Practices Reform Model Act asserted that vocational rehabilitation is its objective, although such a purpose could be added to it without disrupting the statutory scheme. Both of these workers' compensation features should be examined for their possible transferability.

Claims in Dispute: Settlement Approaches. Sometimes parties disagree about crucial issues—such as whether the injury or disease was related to employment; whether it caused a permanent condition; or the extent of permanent disability. When such disputes arise, the parties have the option to settle the claim or to request a Division of Workers' Compensation hearing. Settlement may occur be means of a stipulation of facts or a compromise agreement.

Using a stipulation, the parties reduce the facts to writing, and the Department may determine an order or award based on the stipulation. The stipulation must set forth in detail the manner of computing the compensation due. It must be accompanied by a report from a physician stating the extent of the disability claimed.

Table 4

Selected characteristics of workers' compensation appeals taken from administrative hearings by claimants by number of decided appeals and affirmation of appeals at subordinate appellate forums, 1989[a]

Appellate Level	No. of Appeals Decided	No. (%) of Previous Level Decisions Affirmed
Labor & Industry Review Commission	485	364 (76)
Circuit Court	80	57 (71)
Court of Appeals	21	17 (81)
Wisconsin Supreme Court	5	4 (80)

[a] Source: Wisconsin Labor and Industry Review Commission.

Short of a hearing, a case may also be settled by a compromise agreement. A compromise agreement is considered to be less favorable than a stipulation of fact settlement. For all practical purposes, a case cannot be reopened after 1 year from the date on which an order issues incorporating a compromise agreement.

Stipulations and compromise agreements are subject to the Workers' Compensation Division's review and approval. In disputed cases failing of settlement, a hearing may be held before an Administrative Law Judge. As noted earlier, the proportion of hearings requested is small, and those actually conducted comprise about 2% of claims failed.

The Hearing Process. To apply for a hearing, the employee or his or her attorney must file three copies of a one-page form entitled "Application for Hearing" (WC-7) with either the Madison or Milwaukee Workers' Compensation Division office. If the claim is not settled following application, the Workers' Compensation Division will set a hearing date. Both parties are notified of a hearing date at least 10 days in advance.

Hearings are "semi-judicial" proceedings, with testimony given under oath and subject to cross-examination. Documents and reports are introduced into evidence, and a court reporter transcribes the proceedings.

The ALJ enumerates findings and makes rulings on the ultimate facts in each case based on testimony from all parties, as well as doctors' reports and other pertinent documents and testimony. The plaintiff will usually use the testimony of the treating doctor, whereas the defense may hire its own medical expert(s).

Medical testimony frequently is presented in the form of a written report (to be submitted 15 days before the hearing). Oral testimony is not required.

In addition to medical experts, vocational experts are often utilized to evaluate lost wages. The ALJ may order that the injured worker be examined by a doctor not previously connected with the case.

The Administrative Agency's Budget. The Wisconsin Division of Workers' Compensation's budget was $4,273,962 for Fiscal Year 1989. This budget supported all agency requirements and functions, including 93 full-time personnel; 21 staff attorneys were employed as salaried staff.

The Division's budget is approved and appropriated in procedures consonant with all other state agencies in the Wisconsin budget process. Financial sources are exclusively derived from workers' compensation insurance surcharges and paid into the state's general fund. Expenditures are paid from the general fund and audited as a state function.

Georgetown estimated that the Medical Practices Review Board proposed by organized medicine would cost between $2 million and $7 million to operate annually. The Board and the Wisconsin Workers' Compensation agency would have a comparable staff complement. The proposed Board, however, would include claimant legal representation.

The proposed Board's budget was calculated by varying high and low salary and cost assumptions: a fault-based system entertaining 750 medical injury claims and 250 conduct complaints was used as a constant. Moreover, it was estimated that costs could be paid by a combination of medical negligence premium set-offs, a modest licensure fee surcharge, and users' fees.

The Wisconsin case confirms the general validity of cost estimates related to the Medical Practices Review Board. It also lends confidence to revenue estimates.

The Administrative Law Judge Position: Impact of Fault. ALJs are the key bureaucratic positions proposed for the Medical Practices Review Board, even though they are termed "claims reviewers" and "hearing officers." These are the experts who actualize the term "expert agency." The Board itself is analogous to Wisconsin's Labor and Industry Review Commission. Study staff highlighted pragmatics of the Wisconsin ALJ's position in order to derive implications for administrative resolution of medical malpractice claims.

In Wisconsin, the ALJ is a civil service attorney. When there is an opening for a position, the Division's Administrator interviews four or five applicants.

The starting salary for an attorney without experience is about $28,000; an attorney with about 5 years of experience could expect to earn approximately $40,000 per year. Experienced agency attorneys earn approximately $50,000 per year. Recently, a 20% raise was approved for the ALJs, effective July 1, 1990.

Georgetown staff received mixed commentary about the Wisconsin agency's staff compensation. Some informants thought the salary levels to be attractive, especially in non-metropolitan areas, where housing and the cost of living are not hyperinflated.

Other informants conclude that it is difficult to attract top quality people for the relatively low pay. However, the hours required of professional staff, including ALJs, were thought to be reasonable—40 to 45 hours per week. Legal staff turnover is moderate; the average job tenure is estimated by the Wisconsin agency to be 4.4 years.

Required travel is a drawback cited by several informants who left an ALJ position for private law practice. The Division's 17 ALJs must cover hearings held in 29 cities throughout Wisconsin.

Informants assessed the work of the ALJ to be stressful. On the other hand, the position offers a significant professional growth opportunity—to learn and to see a great variety of cases. It also admits novelty; routine and "burnout" were not reported to be problems.

From Georgetown's staff observations, ALJs appeared to be able to work independently, with over-

sight going to the quality of their decisions rather than the number or nature of their specific rulings. ALJ retention rates mirrored professional personnel generally, with many employed with the Workers' Compensation Division for 4 to 5 years. About 20% of the ALJs are estimated to be full career (long-term) employees.

Going to the matter of bureaucratic indifference to claimants, informants stated that ALJs often develop callousness about the injuries they see most often. This hardened attitude was not seen as necessarily negative. The no-fault system reduced the impact of ALJ attitude upon outcomes. Generally, however, cases likely to be appealed beyond the hearing level involved more profound injuries. In such cases, ALJ attitudes, while objective, were considered to be adequately sensitive.

One comment typified informants' attitudes: "Juries could never do what the ALJs do so expertly and efficiently." There was a general consensus among Wisconsin-based informants, however, that the issues of causation, negligence, and standard of care faced by an ALJ on a Medical Practices Review board could be more complex than those confronted in workers' compensation cases.

Under the proposed Medical Practices Review Board, the fault concept would assure that claims would be more stoutly defended. Linkage of the claims and the discipline systems very likely would intensify that defensiveness. Procedural defenses, however, are limited in organized medicine's Model Act. Thus, delay is less likely to be interposed by parties than is common in lawsuits.

Typical issues in a workers' compensation case are limited to certain fact questions: whether or not the injury is work-related; the date the injury occurred; and the nature and extent of the resulting disability.

Organized medicine's proposal asserts no requirement that an ALJ (hearings officer) be an attorney. Wisconsin informants were questioned about this proposed feature.

Those interviewed felt that a medical claims ALJ should be an attorney, if for no other reason than to add credibility to the position. Credibility can soothe disputes when medical liability issues are very complex and the financial stakes may be high. Some commentators insisted upon a professional degree, a law degree among several options, in ALJ positions. It is a symbol, they believed, of enhanced motivation and commitment, perhaps exceeding public images of the "average civil servant's motivation."

Many Wisconsin informants judged that a trained attorney would feel more comfortable than others in dealing with rules of evidence and administrative procedure. He or she would be better able to manage the parties' attorneys in controversies before the administrative agency.

Quality Standards in Administrative Work Products. During Georgetown's deliberation of contracted papers assessing organized medicine's proposal to take medical malpractice out of the courts, several Advisory Committee members raised concerns about low quality administrative work products. In Wisconsin, study staff inquired about this matter as applied to the workers' compensation system.

Wisconsin insists upon quality ALJ performances. An ALJ initially is hired for a 1-year probationary period. He or she can be discharged during this period without the usual steps that must be taken to separate a civil service employee from employment. Evaluation is systematic during probation, and close supervision is required.

ALJs receive annual evaluations and qualify for merit pay increases. This cures disincentives posed by time and seniority-based regular increases in grade. The Wisconsin Administrator has developed a point-award system to assess work product quality. Bonuses are calibrated for high quality and exceptional work. All persons interviewed concurred that Wisconsin's ALJs are granted ample independence to reach decisions in cases; they are not under pressure to adhere to a certain philosophy.

Other Administrative Personnel. The Wisconsin Workers' Compensation Division appears to benefit from low personnel turnover and dedicated workers. Interviewees cited many reasons for high personnel retention rates and high employee morale. Some attributed these qualities to a "team spirit" characteristic of Wisconsin public service. Others pointed to a "good government ethic" in that midwestern state, the heritage of La Follette's grassroots populist activism. Others recognized a "German-Polish work ethic" that emphasizes hard work and employee loyalty.

Moreover, public service employee benefits are favorable in Wisconsin. They include group health and life insurance; 2 to 5 weeks paid vacation, depending on seniority; group disability benefits; and pension and retirement programs.

Replication of Wisconsin's employee pool in other states may not be possible. But many of the factors contributing to Wisconsin's success can be transferred to a Medical Practices Review Board. Among them is the bonus-based concept undergirding meritorious performance.

The Use of the Pre-Hearing Conference in Wisconsin. Procedures charted for the proposed Medical Practices Review Board emphasize several mandatory conferences aimed to achieve settlement between the parties at an early time and certainly before a formal hearing. These conferences are accompanied by mandatory settlement offers.

Wisconsin's workers' compensation agency recently abandoned pre-hearing conferences. The experience may prove instructive for an administrative alternative for medical dispute resolution.

Formerly, in Wisconsin, a case automatically went to a pre-hearing conference before a hearing was scheduled. The pre-hearing conference had three

stated purposes: to discuss discovery; to educate the parties about the hearing process; and to encourage settlements.

Wisconsin officials found that the pre-hearing conference did little to encourage settlements or to accomplish the other stated purposes. Positions were entrenched, and the pre-hearing conference appeared to fortify them. In addition, the pre-hearing conferences added to the time and expense of the process.

Wisconsin abolished automatic use of pre-hearing conferences. These conferences are currently used only for complex cases. Currently, only 15% of cases that go to a hearing are scheduled for a pre-hearing conference. Since routine pre-hearing conferences have been abolished, the settlement rate has not changed.

Legal Representation Revisited. Georgetown's staff asked Wisconsin informants about claimants' legal representation in the proposed Medical Practices Review Board. Would a free agency attorney, salaried by the state, be able to effectively advocate claimants' interests in medical negligence adjudication?

The arrangement generally was thought to be feasible. However, concerns surfaced about conflicts of interest, real or apparent, that could occur between claimants' lawyers and their employing agency.

Those interviewed unanimously recommended that claimants' attorneys be stationed in an agency independent of the proposed Medical Practices Review Board. However, they also believed that the private attorney contingency fee provides a useful incentive to dispute resolution. They supported organized medicine's proposal of alternative private counsel when claimants wish to retain outside lawyers. Salaried agency attorneys, several informants agreed, would require incentives to maintain high quality legal representation standards. Wisconsin's ALJ merit award program may provide a template for such an incentive system.

Medical Practices Review Board staff attorneys, Wisconsin informants believed, would be placed in conflict by a Model Act provision that required them to police settlement while advocating compensatory awards. In organized medicine's proposal, legal representation would be terminated if the representing attorney judges his or her client to have rejected a mandatory settlement offer "unreasonably." Such a provision would not be permitted under the Wisconsin Code of Professional Responsibility.

The Discovery Process. Medical reports and records are discoverable by both sides to a dispute. However, depositions are prohibited under Wisconsin Administrative Code Ind 80.12.

Most informants judged deposition prohibition to have increased efficiency. Efficiency gains, they believe, outweighed losses to concepts of procedural fairness. At the same time, repeat players have adjusted to this discovery condition. One claimants' attorney said that one just had to "use (his) wits more" at a hearing if surprised by testimony.

Requirements Imposed by a Hearing. In organized medicine's proposal, a hearing is granted the parties as a matter of right. In Wisconsin, study staff inquired about administrative requirements imposed by hearings.

Hearings in Wisconsin workers' compensation cases often last for one-half day or less. ALJs typically conduct two hearings per day, frequently 4 days per week.

One Wisconsin official estimated that each ALJ spends, on average, 3 hours per case going to hearing. This time estimate includes time devoted to written opinions.

It was generally agreed that the hearing proposed for organized medicine's administrative adjudication agency would be longer than that typical of workers' compensation cases. It would be procedurally complex. Depositions, permitted at the discretion of the hearing examiner, were thought justifiable. In contrast to workers' compensation hearings, the medical dispute would require a larger number of exhibits and documents. Informants agreed that each Medical Practices Review Board ALJ proposal would need a larger support system than is required by an ALJ in a workers' compensation setting.

The Use of Medical/Scientific Evidence and Experts. Experts participating in Georgetown's medical malpractice alternatives Delphi survey believed a proposed administrative agency would use scientific evidence more effectively than the courts. Georgetown staff inquired about this matter in the workers' compensation context.

In Wisconsin, no limit is placed by rule on the number of live witnesses that may testify at a hearing. However, the presiding ALJ may limit witnesses if he or she feels that testimony is repetitive or redundant.

Written medical reports are used to a greater extent than live witnesses, apparently for two reasons: doctors generally do not like to testify as witnesses in these cases and may be unwilling to attend a hearing; and, according to practicing attorneys, the two sides usually agree on the contents of a medical report.

Since a relatively small number of attorneys specialize in workers' compensation, the defense and claims attorneys have developed a relationship characterized by trust and rapport. Their common interest usually is to obtain a fair outcome in the case at hand. Case volume assures attorney remuneration. Stipulations therefore are common. This reduces the need for tortuous or predatory discovery.

Within the hearing context described earlier, two types of experts generally testify in workers' compensation cases. The first are medical experts. They describe the nature and extent of the claimant's injury. The second expert category includes a variety of vocational experts. They testify as to the loss of future earning capacity.

When a Wisconsin workers' compensation agency ALJ faces two partisan experts, the law constrains him or her to select one expert's estimate or the other's (within 5%), and not an intermediate position. Thus, experts are encouraged to offer more plausible, less extreme disability estimates.

Parties' choice of a biased or exaggerating medical expert is thought to be restricted by this ALJ opinion election requirement. The success of this method rests on having ALJs who are experienced and knowledgeable. This places a premium on retention of an experienced ALJ staff.

One former ALJ said that if it appeared that both sides' experts were "out of line," the parties would be so informed and would be encouraged to settle the case. It was also pointed out that "hired gun experts" are quickly identified in this system, and their testimony is weighted with bias. Vocational experts received more criticism than medical experts in Wisconsin interviews. Their testimony could be more easily "bought," and it often appeared to be a waste of time or biased against the injured worker.

Informants representing both plaintiffs and defendants complained about the high cost of experts. In Wisconsin workers' compensation claims, each party pays for its own experts. The ALJ is permitted to call his or her expert if necessary to achieve a better understanding of the issues in a case. However, this is done only rarely.

The proposed Medical Practices Review Board, on the other hand, is designed to freely use neutral and independent experts. The Model Act so provides. And Georgetown's estimates of the Board's financial requirements include significant funds for this purpose, more than $1,000 per case filed, and more than $10,000 per case expected to require a formal hearing.

Fairness to the Parties. This case study discovered a consensus among those interviewed: on balance, they concluded, the injured worker in Wisconsin receives fair compensation in a fair adjudication procedure. Most informants thought that some injuries are overcompensated and that others are undercompensated. In some cases, an injured worker will not receive anywhere near his actual wage losses; but that worker will usually not be forced into poverty either.

Wisconsin officials and observers believed that the workers' compensation system accomplishes its basic purpose. Some observers objected to an antiquated benefit rate. That rate is frozen from the date of injury. Thus, a worker who was injured 30 years ago and then received $90 per week at the top of the benefits scale would now still only receive $90 per week. However, the vocational rehabilitation program can help injured workers learn another line of work.

Criticisms advanced by Wisconsin informants emphasized: "the law was more complex than the process required"; injured workers suffered as the result of damages set according to schedule, rather than by an individualized assessment approach; there was a tendency for smaller cases to be fairly and efficiently resolved and compensated, whereas undue delay and confusion could attend to claims for significant compensation for more profound and complex injuries.

Protection and Improvement of the System's Integrity. The Department of Industry, Labor and Human Relations hosts an advisory council on workers' compensation. Advisory council members are appointed by the Labor and Industry Review Commission. The advisory council includes five labor representatives, five management representatives, three nonvoting representatives of the insurance industry, and the Administrator of the Wisconsin Workers' Compensation Division, who serves as chairperson. Beyond advice, the advisory council reviews legislative proposals to amend the workers' compensation program. Only amendments agreed to by the entire council are submitted to the legislature. Over time, the legislature has developed confidence in this review procedure.

The advisory council buffers the workers' compensation program within the political process. It serves as a counterbalance to special interest groups that lobby for legislative change in their own interest.

Most Wisconsin commentators felt that the council system was good way to pass amending legislation. Advisory council hearings are open to the public. One informant observed that it is often difficult to get injured workers actively involved in the advisory council's hearing process. Self-interest is limited. Amendments would usually not retroactively benefit injured workers, and compensation levels are not an issue for uninjured workers.

The proposed Medical Practices Review Board contains no mechanism similar to Wisconsin's advisory council. It is believed that the Board's credibility would be enhanced by an advisory council widely representative of health policy, provider, and consumer interests.

Administrative Appeal and Judicial Review. A case must be appealed within 21 days of an ALJ's decision following a workers' compensation claims hearing. The Labor and Industry Review Commission has 20 days in which to answer the appeal.

The Commission's attorney examines the actual record of each appealed case. The examination includes a summary of testimony or other evidence presented at the hearing. The summary is prepared by the ALJ who heard the case.

The file is then routed to one of the commissioners who will briefly write his or her inclination concerning the case, usually in one or two lines. The file is then routed back to one of the 12 Commission reviewed attorneys, three or four of whom review workers' compensation appeals exclusively.

The reviewing attorney then writes a longer recommendation to affirm, reverse, modify, or remand the workers' compensation ALJ's decision. The review attorney typically reviews one or two cases per day. The attorneys and commissioners meet regularly to

discuss the cases and come to a final decision. Normally, the commissioners accept the review attorney's recommendations.

Since the review is entirely on the record, the reviewing attorneys do not have the opportunity to see the witnesses' manner and demeanor. In contrast to judicial proceedings, Review Commission attorneys are permitted to consult the workers' compensation agency ALJ. They may inquire about the witnesses' demeanor and credibility.

Review Commission attorneys interviewed for this study were asked about ALJ attitudes in the lower agency. Were the ALJs defensive about their decisions? Would the ALJs share with the reviewing attorneys a distinctly biased view?

Review Commission attorneys answered that the ALJs tended to be advocates of their decisions; however, gains were realized in an unclear case from consultations with the ALJ. If a conversation with the ALJ takes place, its substance is entered into the reviewing attorney's record, and it is thus preserved for subsequent appeals proceedings.

Wisconsin observers agreed that Review Commission attorneys render a careful and conscientious examination of appealed cases. Reviewing attorneys are not afraid to reverse an ALJ when warranted. A few informants believed that Review Commission attorneys may spend more time per file than spent by ALJs.

During the Georgetown case study, the Labor and Industry Review Commission had a case backlog and sought approval for additional legal help. The reviewing attorneys are able to rotate among cases appealed from the divisions of unemployment, workers' compensation, and fair employment.

An appeal of the Review Commission's decision may be made to the Circuit Court, but findings of fact made by the Commission, in the absence of fraud, shall be deemed conclusive if substantiated by credible and substantive evidence. About 16% of the cases that reach the Commissioner are appealed to Circuit Court. From the Circuit Court, an appeal may be made to the Court of Appeals and eventually to the Supreme Court.

In contrast to organized medicine's proposed appeals structure, the Wisconsin review of administrative decisions encompasses substantive and procedural matters. The appeals process of Wisconsin workers' compensation decisions seemed to be independent and thorough. Georgetown staff were impressed by the Review Commission's independence. It seemed significant that the appeals level was independent from the operating workers' compensation agency. Appellate personnel exist separately and independently in the state's organizational structure. With a separate reporting structure from workers' compensation ALJs, Review Commission and judicial personnel had no particular allegiance to the operating agency. This arrangement seems, in part, to account for the credibility enjoyed by Wisconsin's workers' compensation system.

Conclusion. Georgetown's case study of "best agency practices" in the workers' compensation system permits a few conclusions and implications.

Historically, the need for workers' injury compensation legislation crystallized at the turn of the 20th century. Relationships between large population groups—employees and employers—had become severely strained. Peace in the workplace was sought amid public awareness that judicial remedies available to injured workers were spare, litigation costly, and employer defenses nearly impenetrable. Unrest was growing. Industrial development was handicapped.

At the turn of the 21st century, similar observations are made with respect to relationships between two large population groups—health care consumers and health care providers. Health care gobbles up a lion's share of the gross national product (11%) while the nation attempts to compete globally in a postindustrial, service-oriented economy.

Health-related litigation apparently burdens the society and the health care professions, pushing up costs through insurance policies and defensive medical practices. No one knows the toll levied by iatrogenic illness from the injured plaintiffs' collective perspective. Medical injury, by all reliable reports, is common, but only a small proportion of those injured appear to have access to the legal system. An even smaller proportion is compensated.

In the future, many justice system planners believe, the administration of justice will be diversified. Administrative adjudication could be one important foundation of such diversification.

The workers' compensation program provides an appropriate and informative foundation upon which a fault-based administrative alternative for medical negligence may be considered. Organized medicine correctly adopted it as a precursor and analogue. That adoption is not without its problems, however.

The principal conceptual difficulty is adaptation of organized medicine's fault-based system to administrative adjudication rooted in no-fault conceptions. We have observed that the fault concept is an important link between medical claims and medical professional regulation, a social policy necessary for the continued integrity of the health care system, but fault-based systems galvanize resistance and stigma.

One way out of this conceptual knot may be the use of qualified fault and qualified no-fault concepts. The means to bridge these concepts may be scheduled compensation awards keyed to authoritative health care practice guidelines. The prospects seem to outweigh the obstacles.

Our studies of Wisconsin indicate that it is possible to establish an Article I adjudication system characterized by relatively high degrees of

- fairness
- efficiency

- prompt, arguably adequate compensation for the injured
- retention of a high level of professionalism and experience in the administrative bureaucracy
- a high settlement rate
- a fair review process

All of these attributes are related to the goals of organized medicine's proposal.

Workers' compensation agencies have been in place for 80 years and therefore have eight decades of experience upon which to draw. Organized medicine's proposal is yet to be tested. The Wisconsin workers' compensation agency experience lends confidence to the prospective operation of a fair and expert medical dispute resolution agency.

Our study from Wisconsin indicated that adequate funding is crucial to the success of a workers' compensation system and will also be crucial to the success of organized medicine's proposal, especially in the start-up years, when factors such as the number of expected claims will be uncertain. There was unanimous agreement throughout our study of an administrative analogue that medical malpractice cases are more complex and will require a greater amount of expertise and a greater amount of resources than workers' compensation cases.

Opinion Surveys of Judges and Court-Related Personnel[37]

In addition to the expert surveys described here, researchers at Georgetown also conducted surveys of judges and other court-related personnel to determine their views as to the desirability of diverting medical malpractice cases to an administrative agency.

First, we conducted a survey of 61 judges and 22 other participants at the Conference on AIDS and the Courts (Miami, Florida) and at the Second Midwestern Conference on Court Management (Milwaukee, Wisconsin), both held in April 1989. Tables 5 to 7 present the aggregate responses. The results showed that roughly one-quarter favored such a diversion (19 of 83 total participants). Approximately the same number (17 participants) were neutral on the question, and slightly more believed that the idea was undesirable (24 participants).

Table 5

Frequency and percentage distribution of opinions about medical malpractice diversion to administrative adjudication yielded by participants in the Conference on AIDS and the Courts, and the 2nd Midwestern Conference on Court Management, April 1989 (*N* = 85)

Response	Frequency	%
Very desirable	20	23.5
Neutral	17	20.0
Very undesirable	24	28.2
No opinion	9	10.6
Different view	6	7.1
No answer	9	10.6
Total	85	100.0

Table 6

Comparison of judges' and non-judges' opinions about medical malpractice diversion to administration adjudication yielded by participants in the Conference on AIDS and the Courts, and the 2nd Midwestern Conference on Court Management, April 1989 (*N* = 83)[a]

Response	Judge		Non-judge	
	No.	%	No.	%
Very desirable	13	21.3	6	27.3
Neutral	14	23.0	3	13.6
Very undesirable	19	31.1	5	22.7
No opinion	5	8.2	3	13.6
Different view	6	9.8	0	0.0
No answer	4	6.6	5	22.7
Total	61	100	22	99.9[b]

[a] Two persons failed to specify occupation and were dropped from the sample.
[b] Due to rounding.

Table 7

Frequency distribution comparison of various types of judges' opinions about medical malpractice diversion to administrative adjudication yielded by participants in the Conference on AIDS and the Courts, and the 2nd Midwestern Conference on Court Management, April 1989 (*N* = 61)

Response	Type of Court Represented by Judicial Survey Participants				
	General Trial Court (*N* = 32)	Appeals Court (*N* = 3)	Special Jurisdiction Court (*N* = 20)	Other Court (*N* = 6)	Total (*N* = 61)
Very desirable	9	0	3	1	13
Neutral	7	1	5	1	14
Very undesirable	8	1	7	3	19
No opinion	1	1	2	1	5
Different view	5	0	1	0	6
No answer	2	0	2	0	4
% of judges' subsample	52.5	4.9	32.8	9.8	100.0

In a second survey, a written questionnaire was sent to recipients of grants from the State Justice Institute seeking their assessment. Of the 81 respondents, 33% favored the idea, 15% were neutral, and 36% were unfavorable, with the balance expressing no opinion or providing no answer. Tables 8 to 10 present the aggregate responses.

Table 8

Frequency and percentage distributions of opinions about medical malpractice diversion to administrative adjudication yielded by a sample of State Justice Institute grantees responding to a mailed pencil/paper questionnaire, November 1989 to January 1990 (*N* = 81)

Response	Frequency	%
Very desirable	10	12.3
Somewhat desirable	17	21.0
Neutral	12	14.8
Undesirable	19	23.5
Very undesirable	10	12.3
No opinion	10	12.3
No answer	3	3.7
Total	81	99.9[a]

[a] Due to rounding.

Moreover, Georgetown University's Editorial Associates comprised another sample. Two hundred lawyers, judges, and scientists responded to the following question:

> Medical malpractice is one lawsuit frequently litigated in State court. To what extent do you regard as desirable removal of this type of action from the courts to an administrative dispute resolution system modeled along a workers' compensation agency with attorney representation of claimants' provision for attorneys' fees?

In this sample of 200 Editorial Associates, 56% found the removal of medical malpractice suits from the courts into some form of alternative dispute resolution mechanism to be very desirable or desirable.

The distribution occurred about equally among the occupational reference groups comprising the survey sample (Table 11). Thirty of the 200 Editorial Associates (15%) had received degrees in more than

Table 9

Frequency distribution by court-related role re: opinions about medical malpractice diversion to administrative adjudication yielded by a sample of State Justice Institute grantees responding to a mailed pencil/paper questionnaire, November 1989 to January 1990 (*N* = 81)

Response	Type of Role Represented by SJI Grantee Survey Participants					
	Court Administrator	Commentator[a]	Judge (Appellate)	Lawyer	Other	Total
Very desirable	3	2	2	2	1	10
Desirable	4	5	5	3	0	17
Neutral	5	2	1	2	2	12
Undesirable	8	4	4	2	1	19
Very undesirable	4	3	2	1	0	10
No opinion	4	4	0	1	1	10
No answer	0	0	2	1	0	3
Total	28	20	16	12	5	81

[a] Commentator = academic or foundation or research institute personnel.

Table 10

Percentage distribution of court-related role re: medical malpractice diversion to administrative adjudication yielded by a sample of State Justice Institute grantees responding to a mailed pencil/paper questionnaire, November 1989 to January 1990 (*N* = 81)

Response[a]	Type of Role Represented by SJI Grantee Survey Participants					
	Court Administrator (*N* = 28)	Commentator[b] (*N* = 20)	Judge (Appellate) (*N* = 16)	Lawyer (*N* = 12)	Other (*N* = 6)	Total (*N* = 81)
Favorable	25.0	35.0	43.8	41.7	20.0	33.3
Neutral	17.9	10.0	6.3	16.7	40.0	14.8
Unfavorable	42.9	35.0	37.5	25.0	0.0	35.8
No opinion	14.3	20.0	0.0	8.3	20.0	12.3
No answer	0.0	0.0	12.5	8.3	0.0	3.7
Total	100.1	100.0	100.1	100.0	100.0	99.9

[a] Favorable = Very desirable + Desirable; Unfavorable = Undesirable + Very undesirable.
[b] Commentator = academic or foundation or research institute personnel.

Table 11
Occupations of Editorial Associates responding to survey

Occupation	No.	%
General practice lawyers	57	28.5
Civil defense lawyers	31	15.5
Civil plaintiffs' lawyers	15	7.5
Patent lawyers	11	5.5
Appellate lawyers	2	1.0
Environmental lawyers	7	3.5
Government lawyers	7	3.5
Other specialized lawyers[a]	15	7.5
General trial judges	1	0.5
Law professors	10	5.0
Physicians	15	7.5
Health scientists	17	8.5
Others: administrative/policy roles	12	6.0
Total	200	100.0

[a] Specialized lawyers include attorneys specializing in health, intellectual property, and real estate law, several serving as counsel to hospitals, businesses, and research organizations.

one discipline. The following combinations were reported: M.D./J.D. (11); J.D./Ph.D. (10); J.D./M.A. (4); J.D./L.L.M./M.A. (health law) (1); J.D./M.A./C.P.A. (1); J.D./M.B.A./M.S. (1); J.D./M.S. (engineering) (1); and J.D./M.P.H. (1).

While these surveys were not designed to provide statistically valid measures of judicial opinion, they do suggest a receptivity to the basic theory informing organized medicine's proposal from a group that might be expected to be more strongly supportive of the current court system. There appears to be significant openness to the concept, as revealed by the large number of respondents who were "neutral" on the issue. If the utility of the administrative approach could be established by empirically sound research, considerable additional support for the administrative approach could be forthcoming.

From the patient's perspective, organized medicine's proposal has not been subjected to representative samples in public opinion polls. There are some suggestions from the literature that recovered compensation under any alternative may be smaller than awards from lawsuits surviving through trial,[18] a period typically lasting from 2 to 6 years. The trade-off appears to be guaranteed access to a claims system and a legal system that Georgetown calculates could result in compensation in as little as half the time of the current system. The stress experienced by claimants may be substantially lower, although empirical data on this are lacking. It appears that the ingredients for a meaningful trade-off, however, are provided by organized medicine's proposal.

How this trade-off may be viewed by health care consumers is not clear, but it may depend upon how the public is approached about it. If an expert agency alternative were introduced to promote consumers' interests in health care quality, and not as a hedge against large jury verdicts, the agency context may not be offensive. The public has expressed misgivings about the health care system but generally appears to be comfortable about patient-doctor relationships. In spite of anecdotal commentary to the contrary in the press, recent surveys disclose the overwhelming preponderance of the public to regard relationships with physicians as satisfactory and personal experience with health care as adequate. Nevertheless, concern about health care system continuity and worst case occurrence coverage worry Americans far more than health care consumers in other industrialized nations. These findings were recently reported by the Louis J. Harris Organization in conjunction with the Harvard School of Public Health and the Institute for the Future.[39]

At the same time, the Gallup Organization, in a poll conducted for the American Society of Cataract and Refractive Surgery (not a member of the Medical Liability Project sponsoring organized medicine's Model Act), found in a nationwide survey, reported in January 1990, that "6/7 of the respondents said they currently maintain a relationship with a physician. 68% of such respondents were very satisfied and 26% of the respondents were satisfied with the quality of care they received from their physicians."[40]

A cost-effective alternative to improved medical practices, then, may strike a responsive chord among the public. Organized medicine has created a design for a new institution that could yield such expectations.

Delphi Survey of Medical Malpractice Experts

The fourth study performed was a twice-iterated survey of 29 experts from a variety of backgrounds, including plaintiffs' attorneys, defense attorneys, malpractice insurers, hospital administrators, physicians, and academic personnel from a variety of fields including law, health policy, and economics.[41] This is a so-called Delphi study, because it attempts to portray agreements and disagreements leading to predictions or scenarios.[42] This tool is used frequently to concentrate expert opinion under conditions of high uncertainty. It is a policy research tool that has gained respect in the technological forecasting field. We used a modified approach and highlighted agreements and disagreements about organized medicine's proposal, but dispensed with scenarios that could only be generated by simultaneous computer modeling with the experts meeting together or networked on-line, features not funded by the present study.

We attempted to enlist experts representing different professions that played roles in adjudicating cases or evaluating the workings of the malpractice system; an obvious challenge was to obtain a sufficient breadth of coverage. The experts were nominated by our project's national advisory committee, and then selected by the researchers from among a roster of nearly 100 candidates. The first 35 were chosen

blindly, in lottery fashion, from sector batches so as to assure sector balance. Fifteen additional persons were selected as a second queue of replacements in the same manner. Twenty-nine persons completed both phases of this mini-study and were paid a modest honorarium for their participation. Our informant sample objective was 30 experts.

Unlike this project's first mini-study, where the commissioned authors were free to structure their analyses according to their own sense of what was important, this survey was more structured. We developed a series of questions focusing upon key attributes of organized medicine's proposal and sought the experts' reactions as to the proposal's likely impact. These key issues included such questions as the proposal's constitutionality, feasibility, potential for improving the efficiency of the current system, and overall fairness. The questions also aimed at focused assessment of specific features of the proposal, such as its use of blind settlement offers, and the specific substantive law changes proposed by the Model Act's sponsors.

The survey was conducted in two phases. The first phase required the experts to complete a questionnaire. The second phase consisted of a personal interview conducted by the members of our research staff. All interviews were conducted by telephone from a uniform schedule. In the paper-and-pencil survey phase, participants were provided with a summary of the proposal, the Model Act, and explanatory materials for completing the questionnaire. The primary findings are summarized here. The second phase, the interview, supplied questions ahead of an appointed telephone call. Also supplied was a summary of the first phase's results, and participants were asked to comment.

A summary of relevant professions included are: attorneys (7); physicians (4); academics (7); insurers (2); health maintenance organization representatives (1); consumer advocates (3); governmental officials (4); and journalists (1). Within a particular area, efforts were made to canvass a variety of viewpoints. For example, in the attorneys category, we surveyed two plaintiffs' attorneys, three defense counsel, one corporate attorney, and one tort reform expert.

The majority of the respondents concluded that a test implementation of the Model Act is warranted. Perhaps the most important issue was the experts' views as to whether the administrative alternative represented an improvement over the current system in terms of overall fairness and efficiency. There are, of course, definitional questions with respect to both goals—fairness or efficiency could be measured according to a number of different perspectives and parameters. We did not attempt a definition of either term.

We urge caution upon the reader with respect to results: with only 29 expert participants, percentage representation, the form in which this information is presented, cannot possibly be representative or statistically significant given the sample bias inherent in the mini-study. Nonetheless, the aggregated opinions, as well as matters avoided, provide some illumination about organized medicine's proposal. Moreover, the research staff believes the participants to be highly qualified in the medical negligence field. We experienced an extraordinary willingness to go beyond requirements to satisfy the survey's requests.

While a substantial minority (approximately 40%) stated that the administrative alternative would likely enhance the fairness of the claims resolution process, the majority (approximately 60%) opined that it would result in little or no improvement in fairness. The reasons given to explain the majority's skepticism varied. Some experts anticipated that the system would place an unfair emotional and financial stress on the claimants, perhaps owing to the lack of a true adversarial representative working on their behalf. Others felt that the procedures established by the proposal favored physicians or questioned the fairness of allowing medical representation on the Board.

With respect to efficiency considerations, the weight of opinion favored the proposal. A clear majority (approximately 60%) stated that the proposed system would likely result in a moderate to great improvement as compared with the current litigation system; 40% anticipated little or no efficiency gains. Among the majority, efficiency gains were expected based upon the speed of resolution and the quality of decision making. The initial steps of filing a claim under the proposed system would be much easier than the filing of a formal suit under the present system. The experts suggested that the most dramatic improvements would occur in two categories of cases: (1) the routine administration of smaller claims which the system currently does not handle well; and (2) handling medical technical disputes in which the Board's expertise would be useful. Skeptics pointed to the inevitable pitfalls of any bureaucratic system. In the absence of an operational definition of "efficiency," however, it appeared to the research staff that most majority respondents designated access and ease of access as their efficiency indicator in the paper-and-pencil survey.

Perhaps somewhat surprisingly, there were no major differences in terms of the occupational or employment settings that appeared to influence opinion on these issues, other than the expected fact that plaintiffs' representatives were uniformly negative. Of course, within any occupational category, there were only a small number of experts; the largest group, for example, was academics, of which seven were included in the survey. A few comments on reactions related to expert status are worth noting.

The physicians surveyed seemed wary of expecting too much from the proposed adjudication system. They tended to give the proposal high marks with respect to efficiency considerations and more compensation delivered to actually injured patients. They doubted that the claims or professional regulatory

regimes would decrease the incidence of medical negligence. They appeared to question whether the administrative forum would reduce the stress associated with malpractice litigation.

Plaintiffs' attorneys saw no advantages and instead highlighted constitutional problems. Plaintiffs' attorneys seemed less likely than all others to weigh the issues overall.

The survey's academics expressed reservations over the proposed adjudication system's potential effectiveness, but seemed eager to evaluate outcomes of an actual demonstration effort. This group attributed the following strengths to the proposal: simplified claims management; potential for fast and efficient small claims settlement; improved handling of technically complex cases; and a cap on awards. They also regarded personnel as critical to the proposed expert agency's success; they were suspicious about state government's ability to attract and retain high quality personnel, and raised additional questions such as the legitimacy of the Board's make-up, specifically, the number of members from the medical profession. They seemed unaware that, currently, in every state, the medical profession occupies most (all in some states) of the state medical boards' authorized seats and that the administrative proposal would be governed by a lay majority upon the Medical Practices Review Board.

The experts generally believed that organized medicine's proposal offered a potentially successful forum in which the facts comprising evidence of injury and fault could be appropriately presented and examined. Sixty-two percent of the respondents anticipated an improvement in the use of medical and scientific evidence in an administrative forum when contrasted with the court system. The reasons for such trust are not clear from first phase survey results, but the follow-up interviews suggested that the improvement was attributed to the expertise of the claims reviewers and hearing examiners, who were likely to be a more receptive, objective, and competent audience for presentations of such evidence. Several respondents qualified their support, noting that the key issue as to whether this benefit would be realized depended upon recruiting high quality reviewers and hearing examiners.

A similar opinion favoring the administrative adjudication proposal was observed with respect to cost of resolving these claims. A majority of approximately 60% predicted that there would be a moderate to great reduction in costs to physicians. These reductions would translate into lower medical malpractice insurance premiums. A similar majority anticipated a reduction in costs to the claimants, owing in part to reduced need for private counsel. Sixty-nine percent of the respondents felt that there would also be reductions to liability insurance companies, but the magnitude and utilization of such savings were not estimated. Most expected that, overall, there would be little or no cost savings, however, because of the likely increase in the number of claims.

In assessing the proposal's ability to improve the quality of health care, opinion split evenly. Forty-eight percent of the respondents predicted little or no improvement; 45% anticipated some or great improvement, with the balance expressing no opinion. It is not clear whether the administrative proposal's linkage between claims and discipline was considered or whether the experts thought that medical negligence was simply a minor factor in achieving quality care. In a related finding, a large majority (72%) opined that implementation of the plan would cause little or no reduction in the incidence of medical negligence. They may have equated low medical negligence with high quality of care. On the other hand, the U.S. Congress Office of Technology Assessment has determined that medical negligence is a weak predictor of health care quality, with much more weight given to medical professional discipline, a proposal feature that the Delphi experts failed to emphasize.[43]

Most did agree that the proposal would spur claims frequency since many small claims would be asserted by claimants who would not or could not otherwise enter the litigation process. Sixty-five percent predicted moderate or great increase in claims frequency. It was suggested that some of these additional claims would be nonmeritorious claims in which the patient was angry with the doctor for some reason. Given the ease of filing, many of these claims, which are currently screened out of the system by plaintiffs' attorneys, were predicted to be filed. Recent findings by the U.S. General Accounting Office's study of Michigan's voluntary medical arbitration system, however, cast doubt upon such an automatic result.[44] If case filing increases occur, it is a matter for research to determine the stimulus for such as increase in the absence of private lawyer incentives.

The respondents were also asked to give their assessment of specific features of the model statute. The experts were sharply divided regarding most features. For example, slightly over half favored the following provisions moderately or strongly: (1) requiring settlement offers to be made at both the initial prehearing conference and again at the final prehearing; (2) placing caps on non-economic damages; (3) changing the standard of causation to one of pure comparative negligence; and (4) limiting judicial review of the Board's actions to procedural issues only. The largest "approval" rating, at about 70%, was given to the use of collateral payments to reduce damages and periodic payments of any award of future damages to a claimant.

Concern was expressed about the proposal's chances of enactment, although the Delphi study was conducted in early 1990, just as the federal government's initiatives in medical tort reform were being readied and before the Harvard Study of New York was released. Two respondents believed that a legis-

lature would enact the plan in its present form. The balance of those answering were evenly split: one-half (13) refused to speculate as to its legislative prospects owing to a lack of familiarity with the local political process; the other half thought political alliances would result in the proposal's rejection by the legislature in their respective states. Thus, some Delphi experts worried that regardless of the proposal's merits, it could fail on purely political grounds.

The survey indicated the experts' beliefs that the fault-based administrative proposal could face significant constitutional challenges if enacted in its present form, but that the proposal would survive constitutional tests. The proposal's primary feature is to abolish civil court jurisdiction in medical malpractice cases in favor of an administrative agency that would resolve claims without a jury. Nineteen experts (65%) anticipated that a constitutional challenge based upon the right to jury trial would be launched against the proposal; many experts also anticipated due process (11 experts) and equal protection challenges (10 experts).

While we do not focus on the likely outcome of the specific challenges, most experts opined that the equal protection and the due process problems could be surmounted if a robust public record of public benefits were made during legislative enactment of the model bill or its successor. The experts were less confident that the right to jury trial argument would be rejected by a reviewing court, but many left the matter unresolved, preferring to suggest that trades for the jury system must be clearly advantageous to a given state's health consumers.

The experts had no consensus on the ideal environment for testing the plan. Several believed that a state with high costs and a high volume of cases would be best suited, while others suggested a small state with low case volume. The experts nominated 25 specific states as possible sites for implementation.

We also asked the respondents what improvements or changes they would make in the proposal. Nineteen of 29 respondents offered changes. The most commonly recommended change centered on the issue of judicial review. Five experts voiced concerns about the limitations that the model statute placed on appellate review. But only one additional respondent insisted that the right to trial be preserved. In response to the question of whether a change to provide a trial de novo was preferable, response was split. Twelve respondents claimed that such an amendment would increase their support; 14 experts said it would not. Five experts said that the availability of a trial de novo would eliminate their support for the proposal, apparently on the grounds that it would undercut the basic premise of the proposal as a replacement for the current system. Four experts noted that such a change would almost certainly make the experiment politically more attractive.

The workers' compensation system has been cited as an organizational analogue for the administrative alternative. During the follow-up interview, the experts were asked what, if any, aspects of the workers' compensation system were transferable. The operational advantage most often cited was the enhanced efficiency of the administrative system. This efficiency was attributed to a combination of development of expertise within the administrative system and abolition of the jury. Other perceived advantages included lower costs for adjudication and consistency of decisions and awards. Operational disadvantages of the workers' compensation system included the increasing "lawyerization" of the compensation process, but no workers' compensation agency offers free legal assistance to its claimants, a unique feature of the administrative alternative. Several respondents noted that the analogy between workers' compensation systems and the proposed administrative system was imperfect, but Georgetown's examination of a workers' compensation agency disclosed in actual design and operation a much better fit than these few experts expected. The removal of fault from workers' compensation cases, three experts suggested, greatly facilitated the function of the compensation board: the Board's task in applying a fault-based standard would be much more difficult. Many workers' compensation agencies, however, operate a limited no-fault system: fault concepts are applied and employer penalties assessed in workplaces failing to prevent recurrent injuries. It may be that some medical injuries are more complex, as a few experts suggested: in compensation cases, the worker may be healthy prior to the injury, whereas in medical liability, the identification of damage and fault is complicated by pre-malpractice illnesses or injury.

The respondents were also asked to compare the desirability of implementing organized medicine's proposal with a lengthy list of other proposed tort reform options. The only alternative receiving overall favorable scores was pretrial screening panels.

In general, the administrative alternative was viewed in more favorable light than the current civil justice system. In general, the experts supported its demonstration. Many of their comments appear to offer ideas to assist a strategic plan for its implementation.

Administrative Alternative Time and Cost Compared with the Civil Justice System

For all the heated talk about the subject, efficiency is a most imprecise concept when it comes to resolving claims between patients and doctors. Two proxy variables for efficient dispute resolution, from many potentially available, are the time required and the costs encumbered.

Adjudication Time. The literature castigates the judicial system generally on time imposed. Justice delayed has been described in the most searing criticisms as justice denied. The U.S. General Accounting Office (GAO) has promulgated time estimates for medical malpractice dispute resolution.[45] Organized medicine's Model Act establishes maximum time horizons for

Table 12

Minimum and maximum time requirements of claims adjudication estimated for a proposed expert agency in medical tort cases[a]

Sequence of Adjudication Process Steps	Elapsed Time Required	
	Best Case Estimate	Worst Case Estimate
Claim filed	10 days[*]	10 days[*]
Claims review conducted	60 days[*]	180 days[b]
Settlement meeting held	n/a[c]	2 days
Single board member review conducted	n/a	30 days
New claims review conducted	n/a	10 days
Peer review conducted	10 days	60 days
Second peer review conducted	n/a	60 days
Attorney assigned	1 day	3 days
Claim to hearing examiner	60 days[*]	60 days
Pre-hearing conference held	1 day	2 days
Discovery completed	90 days	360 days
Pre-hearing conference held	1 day	2 days
Hearing arguments submitted	10 days	10 days
Oral hearing held	n/a	35 days
Findings of fact presented	5 days	10 days
Hearing examiner request expert	n/a	60 days
Expert's opinion	n/a	60 days
Hearing held	n/a	45 days
Findings of fact presented	n/a	10 days
Examiner's judgment	90 days[*]	90 days[*]
Medical board judgment (petition for review)	30 days[*]	30 days[*]
Review panel appointed	n/a	15 days
Briefs filed	n/a	90 days
Oral argument held	n/a	15 days
Opinion of review issued	n/a	30 days
File appeal[d]	n/a	30 days
Intermediate appellate	n/a	60 days
Highest appellate	n/a	180 days
	368 days (1 year)	1,549 days (4 years, 3 months)

[a] Georgetown estimates formulated through staff consultation and based primarily on litigation experience in the State of Virginia. Adjudication time may vary from state to state. The Georgetown estimates are provided merely as a guideline. Note: Georgetown utilized "conservative" time estimates. That is, maximum time was allocated to each adjudicated step in order to accumulate the longest elapsed times from filing to final case disposition.

[*] Elapsed time maximum prescribed by model statute utilized as Georgetown's assumption.

[b] Model statute permits administrative discretion to set elapsed time limits by order on a case-by-case basis. Georgetown assumed elapsed time limit orders (claim amended twice, see footnote c) in this process step.

[c] Elapsed time omitted based on the assumption that merit of the claim is uncontested and that this step is mooted by expert personnel in light of claimant's clear and convincing evidence.

[d] Elapsed time for litigation studies generally does not include appeal.

case processing. An action-forcing mechanism in the nature of early established trial dates, these deadlines permit organization of the events, decisions, actions, and process loops in elapsed time estimates. These time estimates can be arrayed according to case complexity.[46] Table 12 presents maximum and minimum time requirements estimated by this study's staff as extrapolated from the Model Act's provisions.[47]

Georgetown researchers generated two case complexity scenarios and "ran them through" the proposed administrative system. The "simple" case scenario assumed the claimant alleged a misread x-ray of a potential bone fracture. It is termed "Best Case Estimate" in Table 12. The "complex and profound" case assumed the claimant alleged a severe infant birth injury. It is termed "Worst Case Estimate" in Table 12.

Applying the statutory scheme, we calculated that the "simple" case would require a maximum of a little over 1 year from filing to resolution, assuming all steps of the administrative process were taken as prescribed, with the exception of judicial review for alleged procedural irregularities. The "complex and profound" case would require a maximum of 51 months using the same calculation assumptions.

By arraying these estimates against their closest judicial time estimates published by GAO, it is possible to roughly compare the time requirements of proposed administrative and actual judicial dispute resolution systems, respectively. Table 13 presents this information.

In observing that it would likely take about half the time to resolve a "simple" case, and save about a year in the resolution of a "complex and profound" case, no guarantees as to actual elapsed time can be made. One recent study of North Carolina federal court-annexed civil injury arbitration concluded that time is not saved, but money is saved.[48] Clearly, only evaluated experience can measure such outcomes. The administrative proposal's virtue is its prescribed time schedule; administrative law judges could override these prescriptions, but only for cause. The statutory attitude would urge conclusion while permitting case-by-case flexibility.

Georgetown's estimates assumed settlement rates in calculating time horizons for the proposed administrative agency.[49] In general, we assumed that one-third settled at the first mandatory settlement offering opportunity, one-third settled at the first such opportunity after a finding of claims merit, and the remainder dwindled steadily through settlement until 10% of 750 claims filed annually proceeded through a hearing and administrative review of hearing results. This is a more conservative assumption than Virginia's set-

Table 13

Comparison of elapsed dispute resolution time estimates for administrative, fault-based system under organized medicine's Model Act and U.S. General Accounting Office (GAO) estimates of time required for medical negligence actions in the court system

Type of Dispute Resolution and Source of Data	"Complex/ Expensive Case" Elapsed Time[a] (months)	"Typical Case" Elapsed Time[b] (months)
Medical malpractice litigation in the court system documented by the GAO[c]	64.9	25.1
Medical malpractice adjudication estimated by Georgetown from a step-flow analysis of organized medicine's Model Act[d]	51.0	12.1

[a] "Complex/Expensive Case" as applied to the GAO study refers to claims of $1 million or more closed in 1984. "Complex/Expensive Case" as applied to the Georgetown analysis refers to claims which take the maximum amount of time to be processed by the administrative adjudication system. Note that these definitions carry slightly different meanings. However, these constructs are as comparable as Georgetown could find.
[b] "Typical Case" as applied to the GAO system refers to the case with the average disposition time for all claims closed in 1984. "Typical Case" in the Georgetown system is estimated by assuming a more efficient processing of a claim from filing to final resolution, involving the least amount of time necessary for this to occur. Again, these definitions are not exact for each study but allow these two studies to be more comparable.
[c] The figures for disposition time found in this study are averages calculated for different payment ranges. These disposition times are estimates from the time of filing to the time of settlement or final judgment. See *Medical Malpractice, Characteristics of Claims Closed in 1984* (GAO/HRD-87-55).
[d] Georgetown's estimates are formulated through staff consultation and are based primarily on litigation experience in the State of Virginia. Adjudication time may vary from state to state. These estimates are based on "typical" disposition times, whereas the GAO data are based on a calculation of "average" disposition times.

tlement rates in pretrial screening and certification procedures, which approximate the national settlement-before-trial experience.[50]

Although we limit generalization of our time-saving finding to the conclusion that the Model Act seems to accomplish its dispute resolution time savings objective, its potential in this regard is a powerful incentive for a test. This incentive is intensified by the several recent civil justice system studies.

As documented by a 1990 Report of the Federal Court Study Committee, the nation's courts face a caseload crisis of unprecedented proportions.[51] Future intensification of that crisis, absent policy change, is inevitable. From other statistical measurements of caseload growth, and exacerbated by drug and criminal trials, severe docket overcrowding is real, not mere impression.[52] Only partly related to caseload stresses, experts predict continuation of a major squeeze between public expectations of the courts and their dwindling resource bases.[53] According to many judges' observations, including those at the recent mega-conference on the Future and the Courts, civil cases are being forced off the calendar under a crisis of burgeoning caseload. Case delays may become longer as a result.[54] Considering this mounting consensus, administrative adjudication is an alternative worth serious exploration as a means to mitigate the civil justice congestion trend.

Administrative Agency Public Cost. In selecting a means to estimate costs of an administrative adjudicatory and regulatory agency, the Georgetown study adopted a very simple proxy variable in comparing the administrative alternative to courtroom litigation: cost of the forum to government. Public costs and private costs traditionally have been estimated in different accounts. We had the ability to estimate only the former.[55,56] That proposal review exercise, however, disclosed that the forum costs to the public could be significantly less than the cost of court operations (Table 14).

Public cost differentials for the administrative proposal appear to be from approximately 25% to nearly 50% less than judicial system costs for tort and civil actions. An uncertainty element is injected by the woeful state of medical tort action statistics, and it is troublingly unsatisfactory to be deprived of them.

What was startling, however, is that these costs *include* claimants' universal, free, legal representation for their private prosecution of compensatory actions against health care providers.[57] Georgetown's staff used the model statute, assumed a mid-range claims volume of 750 new cases per year, with a complaint volume of 250 complaints against physicians per year, and hypothesized a "cadillac" agency, overstaffed and highly paid, and a low cost alternative.[58] The "cadillac" was estimated at about $7 million annual cost, while the low cost alternative was estimated at about $2 million annually. These costs included operations of *both* the claims and the practice regulation subsystems of the proposed new Medical Practice Board in both high and low cost versions.

We expected that limiting estimates to the public's

Table 14

Comparison of costs to government for resolution of medical malpractice disputes under the administrative, fault-based system proposed in organized medicine's Model Act[a] and the Rand Corporation's estimates of resolution of civil tort actions brought in the state and federal court systems[b]

Forum for Resolution of Health Care Provider Tort Actions[c]	Low per Case Filed (Estimates in 1989 Dollars)	High per Case Filed (Estimates in 1989 Dollars)
State courts		
All torts	$4,739	$12,138
Civil actions	$3,792	$14,665
Federal courts		
All torts	n/a	$12,446
Civil actions	n/a	$14,129
Proposed adjudication agency for health care provider negligence[d]	$2,581	$9,436

[a] Source: Georgetown University Medical and Law Centers, Program on Science, Law and Compensation, 1990.
[b] Adapted from Kakalik, J. S., & Ross, R. L. (1983, September). *Costs of the civil justice system: court expenditures for various types of civil cases*, Table S.8, p. xvii. Santa Monica CA: The Rand Corporation Institute for Civil Justice, R-2985-ICJ. Costs were adjusted to 1989 dollars using the GNP price deflator for state and local purchases of goods and services where 1989 dollars equal 1.35 1982 dollars. Deflator furnished courtesy of the Bureau of Economic Analysis, U.S. Department of Commerce.
[c] Rand "low cost" and "high cost" figures represent government expenditures for one case in low state court and high state court, respectively. The federal court figures represent expenditures for a case in U.S. District Court.
[d] While the Rand figures represent a case that goes through pretrial activity plus one jury trial, the Georgetown estimates represent a "typical" case. A "typical" case cost estimate is derived by dividing an assumed 750 claims into the high and low budget estimates.

costs would bring protest howls from people expecting another study—one financed in the millions of dollars—using real-time simulations of actual cases and encompassing all the transaction costs. Such a mythical mega-study could account for insurance company costs and would crank in the large, but currently unestimable, savings attributable to the administrative alternatives universal, free claimant-counsel plan. And it undoubtedly could account for opportunity cost savings of smaller claimants being able to enter the compensation system as well as expenditures predicted from increasing the pool of smaller claimants. However, those are modeling and simulation studies that beg for future conduct.

From our current review of purely public costs, however, the conclusion is that organized medicine's proposal possibly could be one of the dispute resolution's greatest public bargains. Any number of factors could inflate costs, and any number of bureaucratic phenomena could compromise the expenditure benefits. Such factors can be factored into a follow-on implementation analysis, one of Georgetown's recommendations. The model statute's design, *qua design*, could provide assistance to claimants and the health care professions at lower public expenditures and shorter times between meritorious claims filing and compensation awards.

Relationship between Adjudication Time and Agency Cost. At the same time, a time-related cost factor urges a caveat. Time may work paradoxically in cases that otherwise settle before final resolution in an expert agency. The overwhelming weight of opinion holds that 90 to 95% of cases settle before a final verdict. Georgetown used that assumption in estimating costs necessary to operate organized medicine's proposed expert agency. One would expect that settlement patterns would not change significantly in administrative adjudication. From most reports of pretrial screening panels, medical negligence arbitration, and, especially, Maryland's executive branch Health Care Claims Arbitration Office, cases settled in patterns similar to those observed in the court system.

It is possible that defendant health care providers and their insurers could perceive indirect incentives to drag out the adjudicatory process to the bitter end in small claims and large. Such paradoxical incentives could include last ditch resistance galvanized by automatic disciplinary review of all claims histories, and by quasi no-fault provisions that adjust insurance premiums to experience ratings in the absence of practice guidelines.

If such factors were operative, cases would still be adjudicated in shorter periods than courts could accomplish, but many more cases could span the entire adjudication timeline. This would require bigger agency staffs and more money for caseload management generally. Because the nation's data on medical liability settlements are so incomplete and unreliable, only experience will shed much real light on this puzzle. Georgetown's study report suggested some options for minimizing such paradoxical incentives, and such time and cost reinforcement mechanisms might

be considered in pilot tests of the administrative alternative.

Implications of Medical Tort Reform in Three States

Information gleaned from Michigan, Maryland, and Virginia has been noted throughout this report. This study's staff conducted interviews, developed chronologies, and documented medical tort reform activities in the states of Michigan, Maryland, and Virginia. Each of these case studies has been published separately in *Courts, Health Science & the Law*.[59]

In addition, Georgetown's Journal published a case note about Maryland's professional regulatory and disciplinary system, itself the partial results of an empirical study conducted by a third year law student (now clerk to a Maryland Appeals Court) at Georgetown University.[60]

When added to Professor Morlock's adaptation of the Maryland experience to analysis of organized medicine's proposal,[61] and when added to the U.S. General Accounting Office's studies of Michigan, we are able to distill a few important points. These points may have implications for refinement and implementation of a fault-based, administrative alternative.

In Maryland. Maryland's experience is instructive from a fiscal perspective. The Health Care Arbitration Office, an agency of the Maryland executive branch, budgets approximately $1 million a year to hear about the same number of claims assumed in cost estimates of organized medicine's proposal. When joined to the $2.2 million budget of the State Board of Physician Quality Assurance, the professional regulatory authority, the $3.2 million total supports both functions. This lends confidence to our predictions that both claims adjudication and professional regulation functions are fiscally feasible within the $1.7 million to $7 million estimated for the Medical Practices Review Board.

In Virginia. Virginia's experience, while instructive from several perspectives, discloses the intensely political nature of fundamental decisions about tort reform. Analyst Steven Klaidman concluded that the local medical association's definition of the medical tort problem would have to match closely that fueling organized medicine's proposal. There should, in our view, be a high degree of consensus about the need to change the current system in any demonstration state.

In Michigan. While also notable for arguably the longest, most intensive experience among the states in enacting medical tort reform, Michigan points to the importance of a mandatory adjudication system. When Michigan's arbitration statute was under constitutional attack, few people wanted to use it lest it be later overturned.[62] After the scheme attained an approving constitutional review, the voluntary nature of the arbitration system appeared to hamper it severely.[63]

These observations may be used effectively in planning a demonstration of organized medicine's administrative alternative. They are merely selected highlights. Additional information may be found in the published case study reports.

Questions Unaddressed by the Study: Limitations and a Research and Evaluation Menu

Georgetown's prospective assessment obviously identified questions that lay beyond the academic staff's exploration. Most policy studies will raise questions as well as answer them. This review of organized medicine's proposed medical practices reform institution is no exception. Presented below is a discussion of several of the most prominent questions triggered, but unaddressed, by this study. They are presented roughly in order of the research staff's view of their importance. Combined in their entirety or in clusters, the suggested studies, geared to the following issues, could create a complete implementation analysis to guide a pilot test of the Medical Practices Review Board.

Limitations of the Current Study

First, in the course of this study, Georgetown conducted no projections of increased claims frequency, small claims in particular, upon the cost of a Medical Practices Review Board. During the course of our work, the Harvard review of New York's hospital population established impressive empirical bases for estimating the volume of claimants unserved by the current system. We inquired about the adaptability of the Harvard data tapes for projecting alternative pathways of claims among those 7 out of 8 medically injured people who do not file claims in the current system. We found the tapes to be usable for such purposes. Informal discussions with the Harvard study staff indicated a willingness to share the data with Georgetown staff. Use of secondary data in Harvard's several-million-dollar study would have added considerable analytic leverage to Georgetown's six ministudies, conducted for about $100,000.

Accordingly, in Spring 1990, we formally proposed to the U.S. Department of Health and Human Services a small ($25,000) project to undertake these cost-incrementing and cost-shifting studies. After some initial encouragement, the project could not be expedited. A regular application in the Public Health Service project was recommended to Georgetown staff, but the 6 to 9 months required to approve an application proved infeasible in that the staff capable of undertaking this analysis were scheduled to move on.

Impressed that any demonstration of an administrative alternative would be fortified by congruent assessments of the current justice system's defects in medical tort cases, we sought to survey a large proportion of state legislators preparing to convene at the August 1990 annual meeting of the National Conference of State Legislatures. NCSL officials had been

contacted and had given provisional approval for an on-site survey. A sampling strategy had been formulated. Approximately 8,000 members typically attend the NCSL annual meeting, about one-third of the elected state senators and representatives. A good opportunity existed to question them about establishing an administrative alternative and the acceptability of certain of its features. The survey proposal, however, was directed into the Public Health Service's regular application process, and it was deferred.

It is still timely to conduct these studies. They would provide important new insights. Awaiting conduct, however, the information vacuum deprives our current assessment of additional avenues of information and inference, and it serves as a limiting factor in this report.

A comprehensive constitutional analysis and a policy makers' conference were also urged during the course of this prospective assessment. Lacking funding, they were not conducted. Such omissions also limit, albeit to a lesser degree, this report.

Toward a Further Study Menu

All prospective assessments raise new questions, and our limitations and other observations can serve to forge a future study menu. In the hope that the following can serve to delineate subsequent research efforts, we specify below some of the questions for which answers could yield policy maker and health care consumer dividends. They also could serve to guide test implementation of the fault-based, administrative alternative.

(1) What Would an Informed Opinion Survey among State-Level Policy Makers Disclose? After a decade and a half of medical tort reform, we are nearly as much in the dark about state legislators' views as ever. It will be important in test states—and perhaps with respect to a randomly selected national sample—to survey state legislators' knowledge, attitudes, and preferences with respect to the next stage in medical tort reform, including administrative alternatives. This task is not technically difficult and could be quickly undertaken. Our experience suggests the following dimensions of such a survey:

- What perceptions of necessity, effectiveness, desirability, and feasibility do state-level policy makers express with respect to alternative dispute resolution forums for medical dispute resolution generally, and with organized medicine's fault-based administrative system specifically?
- What perceptions exist of the comparative advantage or disadvantage of nonjudicial medical tort alternative dispute resolution among state legislators?
- How high in the public policy agenda for the several states is further enactment or regulation of medical and other health care provider practice issues?
- What outcomes or impacts are perceived in each state to have resulted, positively and negatively, from the medical tort reforms enacted in that state from the mid-1970s to the present?

Recognizing that surveys can be cumbersome and expensive, Georgetown also recommends a useful substitute: a policy makers' conference at which would be debated the great and small issues related to medical practice reform as viewed from a fault-based administrative alternative. Study staff recommend that such a conference be convened by a neutral third party—foundation, government, or academic institution. Its proceedings should be published and disseminated to the states for review by legislative colleagues across the country.

(2) What Cost Centers Would Be Impacted by a Galvanized Compensation Consciousness among Actually Injured Claimants? Delphi respondents believed that increased case filings would occur in response to establishment of a Medical Practices Review Board. At the same time—under current malpractice and complaint caseload trends—Georgetown staff concluded that the Medical Practices Review Board was affordable. It would cost very little additional money from federal, state, or private auspices, if any, beyond that already spent for medical regulatory efforts. Essentially, start-up funds and those related to evaluation of an experiment would be the most prominent additional dollars required.

We also ascertained that additional forum expenses could be raised from medical personnel and user fees to a level possibly exceeding budgetary requirements. In Wisconsin, for example, the Workers' Compensation Division is budgeted by the state but "appropriated" from insurance carriers. Moreover, licensing fees could be directed to support a new medical practices institution: in many states they are a revenue source for the general treasury. In Wisconsin, the Securities Commission's operations cost about $3 million each year, but the agency raises $7 million per year. Excess revenues over budget are deposited in the state's general treasury. There is every good reason for a medical practices experimentation state to adopt such an approach. It would fund medical professional quality assurance first, and general state expenditures second.

All revenue and expenditures forecasts, however, depend significantly upon caseload. Certainly, the Harvard study documented the *potential* pool of such claims. Beyond that pool, however, the Harvard study's implications remain to be detailed and evaluated. Under various assumptions of outreach, facilitation, and minimum gatekeeping, many of the Harvard study's injured patients *may* become Board clients. How many and under which administrative protocols remain to be determined using the statistics of probability.

(3) What Would a Constitutionalizing Model Study Yield? Constitutional analysis mixing the decisions

favoring workers' compensation and other administrative law schemes with decisions decreeing other schemes unconstitutional would provide a capability for modeling the Medical Practices Review Board. Such an analysis could provide predictive forecasts. It could help contour the Model Act, if it needs such amendment, to survive as a constitutionally valid scheme.

We noted earlier that some experts are critical of the Model Act. Any proposal that, as an exclusive remedy, shifts causes of action from Article I to Article III courts requires an adequate rationale and quid pro quo. Any measure that invalidates judicial subject matter jurisdiction and abolishes a medical negligence cause of action will generate initial opposition.

Organized medicine bears the burden of a thorough analysis focused around these questions:

- In a state-by-state analysis of workers' compensation statutory interpretation, which features were found constitutionally valid and which invalid? Under which theories of constitutional application?
- Which of the principles could or might apply to the administrative systems for medical practices reform? What implications could such applications have for generating amendments that would assure that the Model Act could pass constitutional muster?
- What role, if any, might the fault concept play to differentiate organized medicine's proposal from constitutional analyses of workers' compensation statutes that emphasize the no-fault concept?
- What features of medical tort reform were found constitutional under which features of the appellate law?
- What alternative scenarios, and probability assessments attached thereto, could be envisioned to maximize Model Act constitutionality and minimize vulnerability to constitutional attack?

(4) What Would a Special Analysis of Standard of Care Yield? Changes in the standard of care by means of which doctors are held to be at fault may be a profound element linking the adjudication, regulation, and tort reform systems comprising organized medicine's approach to a new medical practices institution. The Model Act would establish a reasonableness standard to replace a community standard. It would exculpate any act or omission that fell into one of several exonerating categories of professional performance.

Standard of care has been a major issue in legal medicine for a long time. Georgetown's review touched only superficially upon it. Delphi respondents viewed the combination of tort reform and standard of care rules as one possible source of unfairness in organized medicine's Model Act. Their net impact, they argued, would be to lower health care quality standards in the attempt to lower liability thresholds.

Without concentrated attention to this issue, we can only raise questions that in further operational research or conferences warrant answers:

- What would the practical impact be upon various classes of medical negligence litigants were standard of care rules to mirror the "reasonableness in the same or similar circumstances" standard urged in the Model Act? How would impacts differ from those experienced with respect to the community standard rule, now the majority rule, and the national standard rule, urged by some?
- Were the model statute to be amended by addition of practice guideline development mandates, how would such addition be affected, if at all, by the currently adopted standard of care?
- If, as some experts pointed out to Georgetown's academic staff, the Model Act's standard of care were adopted in a large, diversified state, would such standards reinforce tendencies to allocate lower quality health care to the lowest income citizens of that state?

(5) What Effect Would Inclusion of Episode-Related Defendants Have upon the Administrative Forum's Procedures? One concern expressed by the Advisory Committee to Georgetown's project is a procedural problem, the result of carving out for administrative adjudication acts and omissions that may have multiple defendants, such as pharmacists, pharmaceutical companies, or medical device manufacturers. These latter groups are not included under the Model Act's definition of "health care provider." A similar professional regulation problem concerns doctor oversight and discipline, which omits nurses, physical therapists, and other health care providers.

To deal with these excluded groups, we recommend that a workshop be established to analyze the practical effect of excluding certain groups and professions from the coverage in the administrative, fault-based alternative. Questions could include:

- Using simulations, to what extent, if any, would procedural entanglements result from inclusions and exclusions mandated by the Model Act's current version?
- What remedies or amendments might be proposed to relieve procedural snarls, if any were found?
- What cost, time, administrative burdens, or benefits factors could accompany changes in the personal jurisdiction of the proposed Medical Practices Review Board, in both claims and regulatory functions?

(6) How Could Incentives Join Disincentives in the New Medical Practices Institution so as to Reward, Not Merely Deter or Punish? Many experts and

Georgetown staff observed that the fault concept provided the linking undercarriage among the Model Act's adjudicatory, regulatory, and tort reforms. It retained the concept that a health care provider is responsible for a patient's care, a historically durable meta-notion upon which ethical codes are based and can be interpreted.

At the same time, we noted that incentives could be built into negligence prevention, not merely the awful wrath of the law paraded as a threat of punishment for deviation. By reducing professional liability insurance premium costs, for example, for low liability claims incidence and prevalence, health care providers can enjoy a benefit from exemplary performance. By awarding exemplary performance citations, including financial and nonfinancial recognition, excellence strivings can be reinforced as a matter of public policy.

Perhaps such matters can be handled by the rule-making powers delegated to the proposed Medical Practices Review Board. But consideration might be given in a systematic way to their inclusion in a model statute.

(7) What Would Qualified No-Fault and Graduated Compensation Schemes Do to the Model Act's Quality Assurance Objectives? We ask these questions without further specification. They will require the collaborative effort of many disciplines.

(8) What Would an Integrated Medical Practice Guidelines Effort Do to Spur Medical Quality Assurance? Lurking in every recent proposal to quit the expensive practice of defensive medicine and structure provider and consumer health care expectations is reference to practice guidelines. An accountability and measurement device as well as a set of operational objectives, a medical practice guidelines program holds promise of spurring medical quality assurance. It also provides a template, along with the other questions and suggestions discussed above, for evaluating a test of the administrative, fault-based agency.

We suggest that the mandate to undertake such development should be a high priority of the proposed Medical Practices Review Board and should be inscribed in a pilot state's enabling statute.

(9) What Would a Knowledge Production Objective Require? Throughout Georgetown's association with this proposed medical practices institution, organized medicine has reaffirmed its commitment to an experimental trial of an administrative alternative. In the course of our prospective assessment, however, a more compelling, implied objective surfaced. Clearly, the Model Act would create a public policy and health care delivery laboratory. The states, it has been agreed, are the laboratories of our democracy. Organized medicine equips those laboratories with a new dimension for knowledge production. It could create an innovation with its own learning vehicle attached. It provides a base for evaluative research. Adopted in several locations, it could provide the best foundation for health policy studies in the nation's history.

Accordingly, we suggest that this purpose be added to the Model Act's findings and purposes. This addition could serve as the necessary license to augment a bold and comprehensive scheme with an equally comprehensive research and policy development strategy.

Conclusion: Considerations for Amending Organized Medicine's Proposal

The purpose of the commissioned papers, special purpose surveys, and the experts survey was not to reach consensus on the merits of organized medicine's proposal. Indeed, by selecting experts from different fields, and by mobilizing a mosaic of limited scale studies financed with limited funds, we practically ensured a divergence of opinion. Rather, we sought insights into the nature of the debate and the issues. The intended purpose of our on-site studies was to highlight the fault-based administrative proposal's feasibility and to suggest obstacles its implementation might face.

From these diverse information sources, we conclude with respect to the key issue: the proposal warrants implementation. There is widespread, but not universal, support for a pilot program. We further conclude that an expert agency approximating that set forth in organized medicine's Model Act is capable of implementation in a hospitable state that seeks to improve the quality and quantity of medical dispute resolution. As for political matters, it seems clear that such hospitality would be enhanced in states that share the proposal's underlying, coordinated reform objectives, discussed earlier in this report.

Our study indicated that there was general agreement that at least certain aspects of the current system are deficient. Even plaintiffs' and defense counsel, arguably the groups most benefited from civil justice system operations, seemed to acknowledge the problems. Understandably, they are chary of risking the virtues of a known system for the uncertainties of alternatives. The common-sense political economy of medical practices reform dictates that they must be given an opportunity to participate in and benefit from an administrative alternative.

There is disagreement—or at least a lack of evidence as to important factors that handicap the current system: why 15 out of 16 actually injured health care consumers fail to be compensated, or the actual incompetence of juries to fairly compensate such persons, for example.[64] The experts concurred, however, that for many reasons, many injured patients are not able to access the current system. This causes a dysfunction within the tort system with respect to its dual goals of compensation and deterrence. There were shades of difference on these points, but sufficient commonality pointed to the need to find certainty in a fair and efficient alternative. Policy makers who share these observations and seek health care consumer access to a medical injury compensation

system should find organized medicine's proposal attractive. Recent citizen surveys about the civil justice system seem to indicate that the public is ready for improvement.[65]

There was general agreement that the administrative alternative represents an important contribution to the debate: it is not one-sided: and in many respects, the proposal presents a balanced approach. It will, its specific features aside, be an important challenge to the legal and public administration professions in approaching issues of medical liability.

It is clear from a review of our six mini-studies that the issue of malpractice reform cannot easily be removed from the sharp political overtones that typically have characterized the debate. Despite organized medicine's best efforts to elevate the issue of reform above any underlying political agenda, that goal probably has not been reached. In this regard, the proposal's sponsors may be required to go significantly more than half-way to convince policy makers and health care consumers that the proposal is in their interests and that it serves their mutual purposes.

Our state studies, particularly the Michigan medical tort reform experience, imply policy makers' and health care consumers' needs for guarantees that the proposed Medical Practices Review Board would possess the necessary resources and commitment to enforce the adopted negligence standard effectively. Another concern will be whether the Board would be, in fact, impartial. Despite Morlock's suggestion that use of medical professionals in a decision making capacity was not a problem in Maryland's experience, the fact and the appearance of impartiality remains a first order objective as organized medicine moves from the design to the implementation of its model.

The structure of organized medicine's proposal is designed to be impartial. It is not inherently biased. The appointed Medical Practices Review Board would have a majority of nonmedical, citizen members. As the expert agency's fairness centerpiece, claimants are provided free legal representation. The proposal's sponsors, however, appear to be specially challenged: they must overcome the political and social suspicion, if not presumption, that innovations proposed by organized medicine cannot be in the public interest, partly because medical expertise must be brought to bear in every compensation claim and in every disciplinary charge.

This observation poses an unanswerable dilemma.[66] If a primary problem of the current system is its lack of expertise, then medical involvement is necessary; if medical expertise is inherently biased, then medical involvement cannot be included without sacrificing the necessary neutrality. Our Delphi experts, however, were persuaded that medical scientific evidence would be effectively utilized in the proposed administrative forum. Assuming that the investigators and administrative law judges chosen as the new expert agency's operatives will be a mixture of medical and legal personnel, an empirical analysis of medical professionals as legal decision makers may be necessary to determine the nature of any medical bias. Only outcome research and external monitoring for sufficiently long operational periods will be able to illuminate this matter.

The appearance as well as the fact of impartiality, however, can be structured into minor amendments in the Model Act. We recommend that such amendments be given serious consideration.

Going the Extra Mile: Some Suggestions for Elaboration and Amendment of Organized Medicine's Proposal

Fairness: The Claimant Advocacy Centerpiece. Somewhat to our surprise, we found that experts upon whom we relied early in the study for analyses paid scant attention to the proposal's legal representation feature. Our contract paper authors commented only indirectly and superficially about this feature, albeit favorably. A majority of our Delphi survey respondents opined that case filings would be increased, costs to parties lowered, and stress to parties alleviated by the proposed agency's operation, in part due to furnished counsel. But only two survey respondents of the 29-expert queue made direct comments about legal representation; both comments were favorable. Georgetown research personnel noted that a fault-based administrative bill readied for Utah and one introduced in Vermont relied upon outside counsel panels, but reserved this feature's elaboration to rule making under the proposed new agency's authority. This relative silence about claimants' guaranteed legal representation left Georgetown research staff in a quandary.

We had estimated, using our step-flow and elapsed time analyses, that in a "typical" state receiving 750 new claims per year the cost of *outside* legal representation would equal and could far exceed the costs of operating the Medical Practices Review Board. On the other hand, using state-employed attorneys with even modest caseloads, the proposed agency could comfortably pay for counsel within a typical operating budget.

Costs aside, we inquired about legal representation in four case study site visits and at a workshop on workers' compensation agency analogues to the proposed new medical practices agency. From such interviews and discussions, we derived three additional criteria for effective legal services. Their satisfaction appears to be crucial to attaining enhanced access and to achieve the appearance and the fact of impartiality.

First, agency-provided claimants' counsel must be free from conflicts of interest in appearance and in reality. Second, agency-provided counsel must actively assist access to the claims adjucation system. Third, agency-provided counsel must substantially have at their disposal the same tools and incentives available to independent advocates. Study staff applied these criteria against provisions of the Model Act establishing the proposed Medical Practices Review Board.

Conflict-Free Claimant Advocacy. The new institution's Model Act provides for staff attorneys assigned to claimants. Those attorneys report to the agency's general counsel. Our analysis concluded that the intention (free, universal legal representation) could be compromised by these reporting relationships (implying that attorneys must represent the agency's interests at the same time they advocate their clients' causes). We observe that this slip between intentions and organizational design could be easily remedied; staff attorneys could be appointed according to civil service guidelines in a quasi-independent advocacy unit, fiscally responsible to the Chairman of the proposed Medical Practices Review Board, but professionally self-contained except for an independent, non-paid, professional standards advisory committee mandated to issue periodic reports to the public about the Board's advocacy progress.

Active Assistance of Counsel. The Model Act would assign free counsel (while permitting each claimant the option of his or her own, private counsel) after the proposed Board's claims investigator has issued the equivalent of a certificate of merit for a given claim. Georgetown's research staff concludes that active assistance of counsel, and effective access to the dispute resolution forum, hinge upon effective framing of an initial claim. Legal assistance at the time a claim arises—before any investigation or adjudication—is in our judgment required to attain active assistance of counsel.

Going the extra mile to attain active assistance of counsel must involve the trial bar, particularly the plaintiffs' attorneys. Plaintiffs' counsel is experienced in case-finding and prosecution. They possess the experience and track record necessary to galvanize the active outreach built into the administrative alternative's mission. Moreover, the plaintiff's bar is an active political force in most states whose approval for a demonstration effort would constitute an important endorsement.

For these reasons, organized medicine should consider amending its Model Act to include the plaintiffs' bar, specifically, and the legal profession, generally, in setting the standards for and the delivery of legal services. Many operational options are available.

One option is to allocate legal services randomly to claimants, assigning Board-employed attorneys to one claimant cluster and private practitioners to another. In this way, outcomes can be compared, and the best means of standardizing the Medical Practices Review Board's legal services can be measured. Per case payments in the nature of retainers can be made to private counsel with the remainder to be collected through the contingent fee policy already built into the administrative alternative's tort law. That policy caps contingent fees at 20% of claimant payments. This is the allowable maximum typically provided in workers' compensation agencies. It appears, therefore, to be a realistic starting point for negotiations with the plaintiffs' bar in a state evidencing interest in the administrative alternative's pilot test.

Advocacy Tools and Incentives. While the Model Act is silent about attorney-client privilege, avoidance of the appearance of conflicts of interest would be served by an express statutory provision authorizing operationalization of that ethical canon. The Model Act sets the standard of legal care as much as it sets the medical standard. Equally as important, claimants' advocates should expressly be provided all necessary discovery tools. Less usual, but worth considering in organized medicine's ground-breaking, future-regarding proposal, Georgetown believes that financial bonuses for the Board's claimant advocates could be established on a merit-achievement basis. Whether such an incentive system be predicated upon compensation percentages, client satisfaction with advocacy services, or general work product quality remains to be addressed in subsequent implementation analyses.

Fairness in our civil justice conception significantly is related to established principles of due process in the adjudication of important disputes. Several critics have raised concerns that organized medicine's proposal is defective for reasons related to the Due Process Clause of the Fourteenth Amendment of the U.S. Constitution. We describe below several nagging and irrepressible constitutional issues shadowing the proposal. Georgetown's prospective assessment, however, concludes that effective legal representation providing real access to an authoritative dispute resolution forum and earliest possible compensation to injured parties could be an excellent—arguably, the best—guarantor of due process.[67] The Model Act is not far from such guarantees, and from freedom of interest conflicts, in fact and in appearance.

Balanced Forum Governance, Active Outreach, and Minimum Gatekeeping. While latent fairness in organized medicine's proposal is thus heavily related to legal representation, our study pointed out that fairness is also related to the composition of the forum itself—whether it is objective or stacked against one or another of the contesting interests.

In all states, medical regulation currently is dominated by the medical profession.[68] In many states, administration of medical professional oversight and discipline is entrusted exclusively to the medical profession. These entities in recent years have been bombarded by criticism, in part due to their medical governance.[69]

In organized medicine's proposed scheme, the seven-member, governor-appointed, Medical Practices Review Board would be comprised of four or more nonmedical persons and not more than three medically trained members. In terms of sheer numerical balances, then, the Model Act reverses governance proportions and places the lay public as a dominant force. This overall governance design element is carried into day-to-day adjudication and regulation. Three-member panels reviewing administrative law judge recommendations for compensation and disci-

pline would be comprised of two lay members and one medical member. Cynical thinkers could condemn the scheme as a sham and assume that the nonmedical members would front for medical interests. To assuage such concerns, organized medicine could statutorily mandate the Board to publish structured, periodic reports, rather than leave the matter to agency rule making. Going the extra mile in this respect leads to the adoption of continuous decision analysis. Such analysis can be conducted unobtrusively and periodically, as part of the evaluation package appended to the expert agency's pilot operation.

Such reports would be one of several instruments of public outreach upon which the new institution's success depends. Other outreach methods could include prominently advertised 24-hour 1-800 telephone numbers; on-line computer-assisted access from libraries or video-tax services, courthouses, fire departments, and other civic utilities; broadcast media prominence, including interactive radio and cable-TV channels or programs; newspaper columns and public interest advertisements; attractively styled and clearly worded informational brochures distributed to every health care provider. Such measures to implement active outreach customarily are delegated to agency rule making. But to assure their prominence, organized medicine's statutory scheme easily could be modified to specify and mandate them.

Bureaucratic barriers were the voiced concern of several experts assisting the Georgetown University prospective assessment. A periodic access impact review requirement imposed upon the Board would lift the issue to high priority. Just as important is circulation of claims forms and directions permitting claimant (in injury cases) and complainant (in disciplinary cases) completion with minimum help. Coupled with the availability of Board-provided counsel, we see no reason why gatekeeping barriers would frustrate organized medicine's statutory scheme.

Organizational complexity bothered a few of the study's commentators and advisors. Why, they wanted to know, was the Model Act so complicated? After 18 months of living in close proximity to the 300 pages of description and statutory language setting up three subsystems—claims adjudication, professional regulation, and medical tort reform—study staff began to appreciate how hard it has been to get one's arms around the proposed new medical practices institution. It took 2 years to craft the proposal, and it is unrealistic to expect even experts to appreciate its scope and nuances in a short time. We diagrammed the procedural dynamics of the claims and disciplinary functions and compared them with the procedural labyrinths embedded in judicial system resolution of medical tort actions.[70] In practice, we concluded, the administrative system would be no more complex, and possibly less redundant, than litigation.

With additional and simple safeguards discussed earlier, Georgetown's academic staff concluded that fairness latent in the proposed administrative agency could be made manifest. No-fault medical tort schemes could be less supportive of medical practice reforms without substantially reducing the bureaucratic component already blocking professional oversight and needed to administer medical injury claims. And the service ideal, while always subject to worst practices by bad government, can be reified by best practices in good government.

On Constitutionality. Several authors and experts noted the likelihood that the administrative alternative would very likely face significant constitutional challenges. While the constitutional issues are beyond the scope of Georgetown's study, our mini-studies and our legal development monitoring may contribute to an analysis of the proposal's constitutionality. It is an issue that lay outside of Georgetown's study protocol, mainly because we did not have the funds with which to study it properly. At the same time, we constantly encountered the proposal's presumed constitutional validity or invalidity.

The administrative, fault-based proposal abolishes medical tort as a cause of action and prohibits state court subject matter jurisdiction over civil actions for medically induced injury brought by any patient-plaintiff against any doctor-defendant. Some observers opined that such provision, per se, offends the right to jury trial guaranteed by the Seventh Amendment. Others thought that trading a theoretical access to a jury trial for an actual access to prompt expert agency adjudication with free counsel was sufficient quid pro quo for establishing a nonjudicial exclusive remedy and would pass constitutional muster.

Nearly a century ago, the magic words of the law were crafted into constitutionally approving form to bring peace to another segment of the population—employers and employees. The economy was endangered by threatened strikes, related, in part, to workplace injuries. Injured workers' access to the civil justice system was difficult at best. As partial access resulted in increasing prices of the right to action through escalating jury verdicts, however, a means of equalizing the compensatory burden and of reinforcing regulation of employer practices was sought by multiple interests.[71] The analogy has value for a fractious 1990s medical practices constituency lurching toward a better equilibrium of rights and interests.

From 1900 to 1940, the workforce's morale—the engine of our industrialized society—was severely bruised and in need of public policy first aid. The workers' compensation system was designed, and early adopting states, in effect, began public policy experiments that established new institutions after a period of constitutional testing.[73] Many authorities now support such innovation in service to health care quality.[74]

If the law placed great value on employer-employee harmony in this century's first decade, several Georgetown experts reasoned, legislators could choose policies to similarly promote more harmonious rela-

tionships between health care consumers and health care providers during this century's last decade. The pilot testing of an alternative is a better means to such objectives in terms of quid pro quo considerations and public confidence, according to some writers.[73] Deliberate re-invigoration of such relationships could promote health quality and possibly slow the past two decades' steep rise in medical care costs. No prohibition upon such policy decisions—constitutional or otherwise—exists a priori, according to this school of thought; all barriers are political, fueled by economic self-interests of the service industries interfaced with medical practices. If the political will and energy are available, this view holds, legislation shifting medical negligence from Article III to Article I courts could be grounded in a rational nexus and immunized from constitutional attack by providing the same quid pro quo that workers' compensation legislation offered to employers and employees: guaranteed adjudication access and timely compensation for injury in fact.

Not surprisingly, these majestic, Seventh Amendment-related, constitutional questions are intermingled with arguably more pedestrian, but important ones. The model statute's judicial review provisions, for example, drew due process criticism, especially from experts who are members of the trial bar. Two problems recurred in commentary. The first was the elimination of trial de novo upon exhaustion of administrative remedies or, in the alternative, substantive appellate tribunal review. The second was using health care providers as administrative law officers in the administrative system.

We believe these issues deserve analysis with a view toward contouring the Model Act's features to win constitutional approval. However, it is important to make several points.

First, workers' compensation systems do not, for the most part, permit trial de novo. What, besides the no-fault provision, differentiates the constitutional pluses and minuses to urge trial de novo in medical injury adjudication? If the fault/no-fault dichotomy is crucial, a detailed analysis implicating it would be essential. Second, the substantive appellate review documented in the Wisconsin Division of Workers' Compensation discloses an overwhelming approval of substantive adjudication at lower levels. With only 485 appeals of over 77,000 claims filed in 1989, for example, 76% of such appeals were affirmed at the first level of administrative review, and 81% of appeals in the court of appeals sustained administrative decisions. These figures suggest that substantive review in a real expert agency may be truly efficient. If qualification for constitutional approval hangs on maximum efficiency as one indicium of fairness, such conditions may well occur with respect to organized medicine's medical practices model as well as Wisconsin's adopted employer practices policy. Finally, guaranteed legal representation, discussed above at great length, would appear to offset any occupational bias imported into administrative law positions. Subsequent analysis could test this hypothesis with specificity.

Moving across the Fourteenth Amendment's landscape, several critics raised the possibility of the Model Act's vulnerability to equal protection challenges. They informally questioned the constitutionality of a medical carve-out from more general attempts to reform the tort system. That question was also raised in this project's advisory committee deliberation of contracted papers. Why, it was argued by one commentator, should physicians be given their own negligence-mitigating institution? That is certainly a question loaded with assumptions susceptible to analysis and testing. It may, however, mask a more fundamental one leveraging more important analysis: if medical practices and quality improvements were the Model Act's integrated policy objective, why wouldn't an authoritative, public-dominated new institution capable of reaching such objectives be created in the public interest?

In this vein, another Delphi respondent, a Model Act proponent, asked why the public shouldn't be given a coordinated means of bringing medical practices under control? Others answered with a question not invalidated just because of its circular reasoning: why shouldn't health consumers and health providers be entitled to their own institution if the public's interest in health care quality is a dominant policy objective?

While in no way dispositive, the issues cry out to be systematically examined. Taken together, these questions urge concentrated attention, even if they cannot all be answered sufficiently or satisfactorily at the present time. It *is possible* to study the several constitutional questions described above. To date, however, such studies have not been undertaken.

Georgetown's Program for Science and Law published one constitutional analysis by members of the Defense Research Institute (Reynolds, H. E. Jr., Lockwood, R. G., Smart, C. H. Jr., & Schiferl, K. C. (1990). A constitutional analysis of the American Medical Association's Medical Liability Project Proposal. *Courts Health Science & the Law, 1*, 58–74). That analysis concluded that organized medicine's proposals suffer constitutional flaws, any one of them possibly fatal. It is a well-reasoned position, but it is rooted in the current system and fails to recognize any flaws therein. It also was based on an assumption that the Model Act would be adopted as a permanent and fixed policy by some state. In this respect, the analysis did not credit the Model Act as a public policy experiment. Perhaps this misinterpretation was fostered by organized medicine's failure to include in the Model Act a sunset provision. Perhaps it was triggered by the omission of a knowledge production finding objective and provision, the charter element of a public policy experiment. Both are recommended for organized medicine's consideration. Both would represent the sponsors' willingness to go the last mile.

Beyond the new medical practice institution's pro-

posed pilot status, the Reynolds article features two important shortcomings: (1) it failed to look at innovative, related public policies—such as the workers' compensation system—that survived constitutional challenge;[76] (2) it was a position argued by a party at interest in the current justice system whose self-interest must be assumed over the public's interest by its one-sided, straight-line, contextless, approach.[77]

The fact is simply that *no* independent, thorough, and comprehensive constitutional analysis has been applied to the Model Act. The question still daunting organized medicine's proposal is, "Can such an even-handed analysis be designed and implemented?"

Georgetown's study staff answers in the affirmative. It would be possible to mobilize a workshop in a neutral setting for this purpose. The workshop would require prepared papers. Those required papers could be written to highlight the various features of organized medicine's proposal.

Organized medicine's insurance companies—the physician-owned companies writing 50 to 70% of physicians' medical liability policies—proposed the constitutional matter be quieted by giving health consumers a choice of dispute resolution forum in a rival, similar proposal for a new administrative institution limited to medical tort claims adjudication. This almost certainly would moot the constitutional issue. But it also might condemn usage of the new institution. Georgetown's case studies, the workers' compensation system, and less-than-conclusory alternative dispute resolution studies suggest that an authoritative forum tends to be ignored unless the power of the law rests foursquare behind it and mandates such usage. A case in point: a recent report issued by the U.S. General Accounting Office discloses Michigan's voluntary medical dispute arbitration program virtually to be ignored. "We do not see any immediate potential for increased (medical arbitration) program participation," GAO wrote senior members of the Committee on Ways and Means, U.S. House of Representatives, on December 27, 1990, "because of the voluntary nature of the program and lack of incentives for patients to participate."[78]

Beyond questions of the mandatory or voluntary nature of an alternative to the current system, we were impressed with the flexible attitude shown in our surveys toward the administrative proposal's fundamental principles—to take medical malpractice out of the courts and vest dispute resolution in a workers' compensation-type agency. About one-third of survey respondents expressed neutrality about the issue, and the remaining two-thirds evenly split for and against the proposition. It is possible that these "neutrals" would be swayed by arguments for either side not advanced in Georgetown's simple surveys. It is equally as possible that the 1990s climate for dispute resolution innovation has begun to soften positions about dispute resolution policy. One example of that increased flexibility appears in the Federal Courts' Study Committee's recent report.[79]

The FCSC, a congressionally mandated, blue-ribbon planning unit, investigated the federal courts' current caseload crisis and made a host of recommendations for change. The Committee recommended that Social Security Disability cases be removed from the courts and adjudicated administratively. It recommended that Congress create a new Article I court to do the job. In so recommending, the FCSC made the following observations:

> ". . .Social Security disability cases do not receive, on average, the sustained or expert attention from the Article III courts under the present system as they would under a system of expert adjudication concentrated in a single court so that responsibility is not diluted."[80]

Moreover, the Committee recommended to Congress another pilot test: administrative adjudication of equal employment opportunity discrimination claims. These subject matters are as dearly held with respect to rights, powers, privileges, and immunities as issues typically litigated under the medical liability rubric. One could reasonably assume due process sensitivity to such matters by FCSC members in respect to disability and discrimination claims. The FCSC's comments are instructive:

> "The interests of a class of vulnerable citizens are promoted, not sacrificed, when a system of adjudication can be tailored to their particular needs, as we propose be done. The *fairness of the adjudicative system, as distinct from the factual correctness of particular decisions within it*, would remain fully reviewable in the Article III courts."[81] (Emphasis supplied.)

The courts are entering a period of innovation. Perhaps the FCSC—comprised of judges, congressmen, and the nation's top lawyers and legal scholars—believes that rights can be guarded in multiple forums, and powers can justiciably be exercised by administrative law judges. Privileges can be recognized and immunities enforced by dispute resolution alternatives to the courts, the nation's top justice system panel seems to say. In many ways, the FCSC's recommendations seem to parallel initiatives suggested by organized medicine's proposal.

Our recent study of the future and the courts also evidenced considerable support for alternative dispute resolution amid a judicial system future in which "All civil matters seem destined, according to a majority of survey participants, to be displaced by the criminal calendar's speedy trial requirements."[82] At the same time, considerable support was expressed for the proposition that classes of disputes, including medical malpractice, be diverted to alternative systems "within the court structure or in administrative agencies, to deal with repetitive adjudications using well settled law for which the judicial forum may intensify adversariness through judicial delay."[83]

Medical malpractice has been the nation's tort reform laboratory. Between 1975 and 1990, every ju-

risdiction, with the sole exception of the District of Columbia, enacted tort reforms to ease strains imposed by the unavailability and high cost of medical liability insurance, loss of doctors, and a climate of conflict between health care consumers and health care providers. Substantial innovation has been incorporated in the states, the leading edge of tort reform and alternative dispute resolution generally. While no comprehensive impact or outcome studies of this experience have been conducted, most reform features, after a period of constitutional testing, have settled into patterns supportive of the law's intent—to compensate victims of medical negligence and deter malpracticing doctors. The problem is that few people are confident that the law's intent in the current system effectively is being attained. With federal and state court leadership considering alternative dispute resolution using administrative forums, it seems timely and warranted to move medical tort reform into an operational test status, as Randall Bovbjerg puts it, "toward win-win reforms."[84] Organized medicine's proposal for a fault-based, administrative system can serve as a win-win reform.

Moreover, no commentator in the course of the Georgetown prospective assessment suggested that medical professional regulation was functioning well and required no reform. During the course of the study, the U.S. Department of Health and Human Services reported coldly and flatly that medical professional discipline in the states is not working.[85] At the same time, Congress passed legislation mandating a central registry of malpractice actions, a clearinghouse to detect repetitive events in medical liability judgments.[86] Therefore, as to professional oversight and discipline, innovation appears strongly to be favored in the pursuit of quality medical care. To the extent that quality medical care is that free of medically induced injury, medical practices reform as suggested by the Medical Liability Project is overdue. It is ripe for experimentation in new, more effective approaches.

Georgetown's study report regrettably leaves constitutional issues as inadequately addressed as they were at its outset, 18 months earlier. This situation need not endure, however. Combinations of analysis and simulation can help surface the constitutional issues in the context of policy choice and change. We recommend such efforts. The sooner the better—in the public's interests.

Furthermore, it would be possible to model organized medicine's proposal to reflect a constitutionally permissible alternative archetype. That is, empirical documentation of state high court rulings about administrative agencies featuring Article I courts can flag and corroborate factors challenging to a new medical practices institution's underlying legislation. It would then be possible to computer-model "acceptable" legislation that would pass constitutional muster at various degrees of probability. These predictions can be statistically simulated. The question, "Is organized medicine's scheme constitutional?"—so one-dimensional and self-serving in neat "yes" and "no" wrappers—then yields to a different, more objective, more instrumental, multi-dimensional one. "Under what conditions, based on analogous administrative schemes, could organized medicine's scheme constitutionally be optimized, maximized, and minimized?"

Positions on these issues revealed a conflict between competing visions of the tort system.[37] Clearly, the current litigation system creates a rights-vindicating market with risks for both plaintiff and defendants. If the medically injured patient is skillful or lucky in choosing counsel, the current system is desirable. Thus, fair results occur in these cases. In other cases, however, no lawyer is willing to accept the case, resulting in a system properly categorized as inconsistent. The competing value underlying the tort system—just as traditional as the prosecution of claims by the afflicted individual—is consistency in being restored to pre-injury condition. Those praising the litigation system appear to elevate the game principle over the consistency principle. Administrative adjudication advocates, on the other hand, champion the consistency principle. It would regulate behavior and create professional accountability among health care providers. At the same time, litigation system supporters valued the higher levels of compensation that they thought severe iatrogenic injury would be awarded at settlement or trial. Administration advocates valued controlled compensation, which usually means lower payments, in exchange for efficient compensation procedures and more conservatively enunciated standards of health care.

Concluding Comment

Georgetown's researchers believe that such polemics should be brought to a close in favor of demonstrating models that have a chance to work. Organized medicine has shouldered the responsibility of advancing a feasible model. The model deserves to be tested. Such a test should evaluate systematically advantages predicted for the nation's health care consumers, particularly those injured, uncompensated patients lacking access to the legal system.

Georgetown's researchers conclude that the model, with a few changes, can be demonstrated and that such a demonstration can be evaluated to the satisfaction of the state-level policy makers in whose hands rest the next installment in our attempts to achieve quality health care. It is time to forge a creative, productive truce between medicine and justice.

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of America. This paper represents only the views of the authors and not those of any granting institution.

Georgetown University's academic staff took responsibility for study design, conduct, analysis, and this report. The study's staff was aided by an advisory committee that met three times—at the study's initiation; midway, to deliberate four contracted papers; and at the study's conclusion, to review a draft report. The advisory committee, however, neither approved nor disapproved the study, sole responsibility for which lies with Georgetown University. Advisory comments were gratefully received, but this assessment's publication carries neither the committee's endorsement nor that of any of its members. While the advisory committee included a broad-based cross-section of medical liability interests, the absence of the organized plaintiffs' bar representation deprived the study staff of that sector's views. One advisory committee member had been a plaintiffs' attorney, and several plaintiffs' attorneys provided interviews and Delphi surveys.

Medical Malpractice Alternative Evaluation Advisory Committee members included the following persons, among whom only the study funders officially represented their employing organizations. For others, organizational affiliations are named only for purposes of reference: Christopher Bladen and Mary Byrnes, U.S. Department of Health and Human Services; Leslie Cheek III, Crum & Forster Insurance Companies; Deborah Chollet, Georgia State University; Martin Connor, American Tort Reform Association; Bertram Cottine, Bureau of National Affairs, Inc.; David J. Danelski, Stanford University; the Hon. Dave Durenberger, U.S. Senator, Minnesota; Ronald Gass, American Insurance Association; Bryant Galusha, M.D.; Kenneth Heland, American College of Obstetricians and Gynecologists; the Hon. Thomas P. Jackson, U.S. District Court, District of Columbia; George McGee, M.D.; Sally Narry, U.S. Small Business Administration; Robert Patterson, Pennsylvania Blue Cross; Seymour Perry, M.D., Georgetown University (Chair); Larry P. Polansky, Esq.; Jean Polatsek, American Hospital Association; the Hon. Joshua L. Robinson, 26th Judicial Circuit, Courts of Virginia; Victoria P. Rostow, Powell, Goldstein, Fraser, & Murphy; the Hon. James H. Scheuer, U.S. Representative, 8th District of New York; Dr. Howard Shapiro, American College of Physicians; Geoffrey R. W. Smith, McDermott, Will & Emory; James S. Todd, M.D., American Medical Association.

The study's academic staff included: Professor Franklin M. Zweig (principal investigator from 1/1/90); Sandra S. Thurston, Esq; Pamela S. Coukos; S. Diane Turpin; Christopher G. Jernigan; David C. Judge; Edward J. Burger, M.D. (principal investigator to 12/31/89); Dr. Rosita Thomas (consultant); Clifford A. Dougherty, Esq. (consultant).

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Endnotes

1. Medical Liability Project, American Medical Association/Medical Specialty Societies. (1988, January). *A proposed alternative to the civil justice system for resolving medical liability disputes: a fault-based administrative system.* Chicago: American Medical Association; Medical Liability Project (1989, May). *Tort reform codification: model medical liability and patient protection act.* Chicago: American Medical Association (hereinafter referred to as the "Model Act"). See also *Courts, Health Science & the Law, 1,* 87–120.

   For a description of the proposal and its rationale, see Johnson, K. B., Phillips, C. G., Orentlicher, D., & Hatlie, M. J. (1989). A fault-based administrative alternative for resolving medical malpractice claims. *Vanderbilt Law Review, 42,* 1365; K. Johnson, K. B., Phillips, C. G., Orentlicher, D., & Hatlie, M. J. (1990). The American Medical Association/Specialty Society tort reform proposal: a fault-based administrative system. *Courts, Health Science & the Law, 1,* 6–18; see also Phillips, C. G., & Esty, E. H. (1989). A fault-based administrative alternative for resolving medical malpractice claims: the AMA-Specialty Society Medical Liability Project's proposal and its relevance to the crisis in obstetrics. In Roston, V., & Bulger, R. (Eds.) *Medical professional liability and the delivery of obstetrical care: volume II, an interdisciplinary review* pp. 136–160. Washington, DC: National Academy Press (Institute of Medicine). For ease of reference, the proposal will be referred to here simply as the "organized medicine proposal."
2. The proposal was endorsed in 1989 by the Institute of Medicine (IOM), a prestigious arm of the National Academy of Sciences. In its study of the impact of medical liability upon the obstetrics and gynecology fields, IOM stated, "the (study) committee determined that, based on the theoretical literature available, three alternatives appear particularly promising (including organized medicine's proposal)... and recommends that states evaluate these three proposals, among others, for implementation on a limited basis..." No-fault and private dispute resolution contracting were the other institutions recommended.

   However, earlier reactions to organized medicine's proposal were less enthusiastic; see Stevens, C. (1988, March) Can the AMA sell its own brand of tort reform? *Medical Economics, 55,* 23–29. [Experts in the medical, legal, and insurance fields were interviewed about organized medicine's proposal and labeled the plan as everything from brilliant to outrageous. James S. Todd, M.D., then Deputy Executive Vice President of the American Medical Association, stressed the plan's intention to increase the number of patients who can have their claims evaluated, because they will no longer have to convince lawyers to take their cases; Harvey F. Wachsman, a New York neurosurgeon-turned-plaintiff's-attorney, was quoted as saying, "I hope people won't be fooled into expanding the power of state medical boards that don't function properly to begin with"; other plaintiffs' attorneys questioned the constitutionality of taking away the plaintiffs' right to a jury trial; H. Martin Hunley, Jr., a New Orleans defense attorney, thought the plan could work if it were amended to allow litigants freedom to resort to the courts after a prescribed administrative hearing; other lawyers predicted that the proposed system would be very expensive]; see also Holzman, D. (1988, December 12). Malpractice crisis therapies vary. *Insight (Washington Times), 4,* 54–55 [He emphasizes the difference of opinions concerning medical malpractice remedies].

   Several states have shown strong interest in organized medicine's proposal, however. Vermont has introduced legislation to enact a close variation informed by organized medicine's basic plan in the 1990 and 1991 legislative sessions. Utah is readying legislation after an extensive self-study process. Michigan, a state operating through tort reform coalitions, has indicated interest after a decade's string of medical tort reform actions. Summaries of these developments are presented in *Insight into Courts, 1,* Nos. 1 and 2, available from the Program on Health, Science & Law, Georgetown University Medical and Law Centers, 219 Kober-Cogan Hall, Georgetown University, Washington, DC 20007.
3. While medical negligence adjudication and professional regulation traditionally have been "local" subject matter, lodged in the several states, new federal initiatives took form during the course of the Georgetown study of organized medicine's proposal for administrative adjudication. These initiatives provide both authoritative and financial impetus for demonstration of state level alternatives for medical tort reform. Most important of these developments has been the establishment of the new Agency for Health Care Policy and Research (AHCPR), established by Congress in December 1989 as the eighth and newest agency of the U.S. Public Health Service. AHCPR's mission is "to enhance the quality of patient care service through improved knowledge that can be used in meeting society's health care needs." See *AHCPR purpose and programs.* (1990, September). Public Health Service, U.S. Department of Health and Human Services; available from AHCPR, Parklawn Building, Room 18-12, Rockville, MD 20857.

   Most recently, AHCPR began to set an agenda for federal support of medical liability research and demonstration. In February 1991, AHCPR convened a leadership conference in the nation's capital for that purpose. See *Issues in medical liability: a working conference.* (1991, February), available from Kathleen Hastings, R. N., J. D., AHCPR. Results of the con-

ference are expected to be encompassed in research and development protocols for the federal government.

Moreover, the President's 1992 Budget urges nearly $1 billion in funds to support demonstration efforts related to federal health care programs. A 2-year study of tort reform needs, conducted by the Office of Management and Budget, resulted, in part, in waiver provisions in programs administered by the Health Care Financing Agency to demonstrate innovative new programs to reduce medical liability and promote health care quality. Such efforts can potentiate support for organized medicine's proposal.

Other calls for different approaches have been introduced at the federal level. In 1990, Representative Nancy Johnson (R-Conn), of the House Ways and Means Committee, introduced H. R. 4566, a bill that would mandate arbitration of Medicare cases, called "Medical Malpractice Dispute Resolution Act of 1990," 101st Congress, 2nd Session; Senator Orrin Hatch (R-Utah) introduced S. 2934, the "Health Care Access and Patient Protection Reform Act of 1990," which was referred to the Committee on Labor and Human Resources. The Hatch Bill, planned for reintroduction January 1991, is part of a comprehensive legislative package of bills to reform the health care system. It supports funding to the states for development and implementation of alternative dispute resolution systems programs in the medical liability area, including a fault-based administrative system; provides for other medical liability reforms, including limits on awards for non-economic damages, reducing awards by the amount of compensation from collateral sources, and limiting attorneys' contingency fees; strengthens the activities of state licensing and disciplinary activities; and improves state programs for educating state professionals.

4. However, it is clear that a research and demonstration project can be operated in the medical liability area, and that sufficient time, at least 5 years, is necessary to do so. The State of Maine, for example, enacted Public Law 931, which established a Five Year Medical Liability Demonstration Project that involves all sectors concerned with the topic and develops practice parameters for emergency medicine, obstetrics and gynecology, and anesthesia specialties. Safe harbors (affirmative defenses in tort and limited immunities in public policy) are created for liability claims brought against practitioners who agree to implement practice parameters adopted by the state's administrative procedures act. See Smith, G. H. (1990, October). "Maine's liability demonstration project—relating liability to practice parameters. *State health legislation report.* Chicago: American Medical Association. For other multi-year demonstration projects in Colorado and Minnesota, see *Issues in medical liability: a working conference* supra note 3.

5. On the other hand, critics may not put much stock in demonstration of the administrative alternative or other pilot projects. See Peters, J. D. (1990). Critique of the American Medical Association's model medical liability and practices reform act. *Courts, Health Science & the Law, 1,* 51–57. [He stresses the need for a limited test that could generate information on feasibility since, "without such evidence, to replace a system that has worked to resolve civil disputes for hundreds of years with an untried system that is radically alien to the citizenry is more than legally unsound. It defies common sense"].

6. This assessment's limitations are presented systematically in this report's section entitled, "Questions unaddressed by the study: limitations and a research and evaluation menu." In general, the study is burdened by its orientation, that is, a prospective assessment. The policy research literature generally terms such research as "meta-studies" and endorses them as a means to define the terms of natural or planned public policy experiments. See, generally, Gergen, K. J. (1968). Methodology in the study of policy formation. In Bauer, R. A., & Gergen, K. J. *The study of policy formation,* pp. 205–238. New York: The Free Press, Macmillan Books. The current assessment is subject to various elements of the methodological biases discussed but adopts the "formative" method prescribed for such prospective analyses. See, generally, Zweig, F. M. (1979). *Evaluation in legislation.* Los Angeles: Sage Books, especially Chapters 5–10. Also, see generally, Zweig, F. M., & Marvin, K. (1981). *Educating policymakers for evaluation.* Los Angeles: Sage Books, especially Chapter 1. As a theoretical bias, this current assessment impliedly adopts a group model of public policy making, that is, policy is a product of interactions among interest groups. For a more complete description of the group model and interest group theory, and other models, see Dye, T. R. (1978). *Understanding public policy.* Englewood Cliffs, NJ: Prentice Hall, especially Chapters 1, 14, and 15. For a normative orientation generally followed in the current assessment, see "Forward: health care as a laboratory for the study of law and policy," in Havighurst, C. C. (1988) *Health care law and policy: reading notes and questions.* Westbury, NY: Foundation Press.

7. For an overview of the types of criticisms leveled against the litigation system, see Metzloff, T. B. (1988) Researching litigation: the medical malpractice example. *Law & Contemporary Problems, 51,* 199–200. For a broad survey of the steps taken to reform the litigation system, see Ludlam, J. E. (1990, November and December). The real world of malpractice tort reform. *Journal of Health and Hospital Law, 23,* Nos. 11 and 12.

8. Bovbjerg, R. R. (1990). Reforming a proposed tort reform: improving on the American Medical Association's proposed administrative tribunal for medical malpractice. *Courts, Health Science, & the Law, 1,* 19–28.

9. Harvard Medical Practice Study. (1990). *Patients, doctors and lawyers: medical injury, malpractice litigation and patient compensation in New York: the report of the Harvard Medical Practice Study to the State of New York.* Cambridge, MA: Harvard University (hereinafter referred to as "the Harvard study." [This study concludes that ". . . the tort system is providing very limited access to compensation for a large majority of patients who suffer negligent adverse events, and none for the much larger numbers who are injured due to no one's fault." Id. at 11-5. The study emphasizes that 1% of patients were negligently injured and that an additional 2.8% suffered adverse outcomes. It concludes that a no-fault medical compensation system is feasible and recommends a severely restricted universal method of compensation that would cost New York's medical liability cost center $894 million. The study is inconclusive about the deterrent effect of the current tort system and about the negligence-fortifying effect of a no-fault system. Id. at 11-8.

10. U.S. General Accounting Office. (1987). *Medical malpractice: a framework for action,* at 23. The costs, in turn, often hinge upon how much money plaintiffs' attorneys must "front"—advance—for each case. Some plaintiffs' attorneys now require in retainer and contingency fee agreements that certain costs be paid in advance by the client. The major costs for bringing suit, however, relate to payments to experts. Given the rising costs of expert witness examinations and testimony, some plaintiffs firms appear to reject a case unless it is meritorious and the recovery is some multiple of the front costs. The GAO estimates may be low. In a private communication, Leonard Ring, then Chairman of the Torts and Insurance Practice Section of the American Bar Association, estimated in March 1990 that it is now common experience for plaintiffs' attorneys to assume initial costs for medical liability cases in the amount of $50,000 per case. Consequently, many plaintiffs' litigators are unwilling to accept cases if the estimated recovery is under $100,000).

11. See U.S. Department of Justice. (1986). *Report of the tort policy working group on the causes, extent and policy implications of the current crisis in insurance availability and affordability.* "because of the complexity of the issues, judges allow juries to hear medical views that may not be scientifically credible." (p. 13). Also see Institute of Medicine. (1989). *Medical professional liability and the delivery of obstetrical care.* Washington, DC. National Academy Press. [The study concluded that the traditional tort system is a slow and costly method of resolving obstetrical disputes and is contributing to the disruption of delivery care in the United States, and that both health care providers and patients have lost confidence in the use of the traditional medical tort system. It was recommended that states

consider alternatives to the tort system for resolving medical malpractice claims."

12. See Daniels, S., & Andrews, L. (1989). The shadow of the law: jury decisions in obstetrics and gynecology cases. In IOM study report, volume II, supra note 1. [The report finds that only a small proportion of injury-causing medical errors leads to claims against the physician, and fewer result in a jury trial. If there is a jury trial, physicians usually win; awards may be high but are not excessive, given the seriousness of the injuries.]
13. O'Connell, J. (1986). Neo-no-fault remedies for medical injuries: coordinated statutory and contractual alternatives. *Law & Contemporary Problems, 49*, 126. See Relman, A. (1990, March 1). Changing the malpractice liability system. *New England Journal of Medicine, 322*, 626. See also Manuel, B. M. (1986). Professional liability—a no-fault solution. *New England Journal of Medicine, 322*, 627–631. See also, Reynolds, Rizzo, & Gonzales. (1987). The cost of medical professional liability. *Journal of the American Medical Association, 257*, 276; Rueter, J. A. (1984, November–December). Defensive medicine. *Congressional Research Service Review, 5*, 18–19, 30; Burda, D. (1987, April 5). Liability reshapes hospital/physician relationships. *61*, 56–60; Drummond, H. (1983, May). Over-preventive medicine: how doctors and lawyers are making mountains out of moles. *Mother Jones, 8*, 12–14, 16–17.
14. Priest, G. (1987). The current insurance crisis and modern tort law. *Yale Law Journal, 96*, 1521, 1582–484.
15. See Litan, R. E., & Winston, C. (Eds.). (1988). *Liability: perspectives and policy*. Washington, DC: Brookings Institution. [The report includes chapters on the following areas of tort law in which the insurance crisis has been most pronounced: medical malpractice, environmental liability, occupational liability, and products liability; and it summarizes policy recommendations. It concludes that stiffer regulation of the insurance industry would be counterproductive; that tort law would more efficiently deter undesirable behavior if judges encouraged juries, in deciding which parties should bear the costs of accidents, to balance the costs and benefits of the behaviors of the plaintiffs and defendants; that damage schedules should be established for pain and suffering awards; and that not enough is known about the costs and benefits of the current liability system to recommend replacing it with a government-administered compensation program.]
16. See Danzon, P. M. (1988). Medical malpractice liability. In Litan & Winston, supra note 15, at 101–127. After surveying broadly the tort reform field, the author concludes, "The search for cost effective reforms should focus on modifications of the tort system to reduce uncertainty and reduce inappropriate levels of compensation while retaining a fault-based rule of liability." Id. at 127.
17. Organized medicine's proposal argues in favor of the tort system—albeit a converted liability system, reformed and administered in a new institution—to achieve fairness for health care consumers and providers. The new agency would be modeled upon workers' compensation procedures but would apply fault concepts without limiting compensation.
18. The end result of the medical tort reform movement has been legislation in every state (only the District of Columbia has failed to enact medical tort reform) to smooth the way for doctors and patients to come to terms with medical negligence, medical liability insurance shortages, and a snarled judicial system. That legislation and the case law appended to it are succinctly summarized by Bannon, N. K. (1989). *AMA tort reform compendium*. Chicago: American Medical Association. Bannon summarizes state-by-state enactments regarding *ad damnum* clauses, arbitration, attorney fee regulation, collateral source rule, frivolous lawsuit penalties, joint and several liability rule, limits on recovery, patient compensation funds, periodic payment of damages, and pretrial screening panels. For another survey approach, see Spernak, S. M., & Budetti, P. P. (1991). *Compendium of state systems for resolution of medical injury claims*. Agency for Health Care Policy and Research, U.S. Public Health Service, Department of Health and Human Services.
19. Johnson, K. B., et al. A fault-based administrative alternative for resolving medical malpractice claims, supra note 1, at 1376 ("These changes have been tried for over a decade in most states without resolving the crisis surrounding the availability and affordability of professional liability insurance"). "Neither consensus on goals nor good information on means is currently at hand," concludes Randall R. Bovbjerg in his 1988 survey of medical malpractice legislation, ADR, and insurance reform enacted in response to the medical liability "crisis" of the 1970s and 1980s. See Bovbjerg, R. R. (1989, Winter). Legislation on medical malpractice: further developments and a preliminary report card. *University of California at Davis Law Review, 22*, 556.
20. See O'Connell, supra note 13; Harvard Medical Practice Study, supra note 9. See also Sloan, F. A., & Bovbjerg, R. R. (1989). *Medical malpractice: crisis, response and effects*. Washington, DC: Research Bulletin, Health Insurance Association of America. [Legislatures have addressed statutory reforms for problems of insurance availability, medical quality, and tort reform, and it is tort reform that has received the most attention from legislatures and analysts alike. Some changes, such as the shortening of the statute of limitations, have resulted in reducing payments to claimants; however, the issue of fairness to claimants is still unresolved.] a general discourse on the advantages and disadvantages of alternative dispute resolution and alternate systems are in included in Nelson, L. J. (1986, Fall). Medical malpractice and alternative dispute resolution. *American Journal of Trial Advocacy, 10*, 345–363. However, the Model Act provides screening (determination of merit as well as valuation of damages) as an expert function procedure and a ministerial act of the state's medical practice review board. Its settlement-inducing activities are internal and subordinate, required through blind-offer settlement conferences. There is some suggestion that recovered compensation under *any* alternative system may be smaller than that surviving the litigation system through trial. See Note. (1983, Spring). Medical malpractice arbitration: a patient's perspective. *Washington University Law Quarterly, 61*, 125–156. Time and stress required may be substantially less, however, and valuation of payments awarded early has not been reported in the literature.
21. Johnson, supra note 19. Organized medicine's new, expert agency would be modeled upon workers' compensation procedures but would apply fault concepts without limiting compensation. The Harvard study championed a no-fault institution, based in part upon workers' compensation program templates, but achieving feasibility by limiting compensation to injury experienced after 6 months' duration. Presumably deaths induced by medical injury (13,000 of which were documented in New York in 1984) would be compensated by a uniform schedule. Early comparisons of the fault-based and no-fault systems have termed the former "a less drastic alternative" and the latter as resulting in reduction of "the enormous costs of defensive medicine" and much lower average awards. See Relman, supra note 13.
22. Tort Reform Codification, supra note 1, Model Act §202(a) and (b). During this initial stage, a physician may make a settlement offer but must notify the claims reviewer of the offer, at which time an attorney will be appointed by the Board to review the fairness of the offer on behalf of the claimant (§203(b)). In all instances in which the claimant has the option of retaining private counsel, compensation is limited to a set sliding scale of 40% of the first \$50,000 recovered, 33⅓% of the next \$50,000 recovered, 25% of the next \$100,000 recovered, and 10% of any amount over \$200,000 recovered (§205(b)).
23. Model Act §211(a)—(g).
24. This standard of review is modeled on the standard applied by courts to decisions by administrative agencies. See 5 USC 706 (1982).
25. See, e.g., Campbell v. United States, 325 F.Supp. 207, 210 (MD Fla. 1971).
26. The Board would be required to consider a variety of factors in making this reasonableness determination, such as any special expertise of the health care provider, the state of medical

knowledge, the availability of health care facilities, specialized equipment and personnel, and reasonable access to transportation and communication facilities. Similar to other administrative agencies, the Board will be given rule-making authority to implement statutory standards and requirements. The Board will exercise its authority in the manner prescribed by the state's administrative procedures act. The validity of any rule promulgated by the Board will be reviewable by the courts on the ground that it is arbitrary, capricious, or in excess of the Board's statutory authority.

27. See, e.g., Fitzgerald v. Manning, 679 F2d 341, 348 (4th Cir. 1982). See Havighurst, C. C. (1986). Altering the standard of care. *Law & Contemporary Problems, 49,* 265.

28. Caruso, A. (1990). The time present foundation of Maryland Medical professional regulation: recommendations for a better future. *Courts, Health Science & the Law, 1,* 251–262; Fellmeth, R. C. (1989, Spring). Physician discipline in California: a code blue emergency. *California Law and Regulation Reporter, 9,* No. 2; Committee on Small Business, Subcommittee on Regulations and Business Opportunities, U.S. House of Representatives. (1990, June 8). Testimony of Richard P. Kusserow on state medical boards and medical discipline; Inspector General, Office of Evaluation and Inspections. (1990, April). State medical boards and medical discipline. Washington, DC: U.S. Department of Health and Human Services; Simmons, N., McCarthy, P., & Wolfe, S. (1990, June). *6892 questionable doctors.* Washington, DC: Public Citizen's Health Research Group. [The Inspector General reported that case backlogs, as well as staff shortages, remain a serious problem for state medical boards. Moreover, although licensure renewal fees, which can serve as a major funding source for addressing these shortages, have been increasing, much of the revenue that state governments obtain from these fees has not been going to the boards.]

See also Model Act, §102. The Model Act specifies that the Board's seven members shall consist of three health care providers, at least two of whom shall be physicians, and four persons who are not health care providers. While health care providers are brought under the Medical Practices Review Board's claims adjudication jurisdiction, only oversight of physician performance is brought under its professional regulation authority. In reviewing complaints against physicians, the system is headed by a hearing examiner and overseen by a Board committee, comprised of two lay persons and one physician. Id. §300. One criticism of medical discipline has been its attention to issues not involving standard of care: and when substandard care is alleged, many states vaporize charges by providing insufficiently enumerated grounds for discipline. The Model Act specifies grounds in §301 and permits complaints from multiple sources in §302. Coupled with the statutory scheme's reversal of medical dominance, the Model Act channels toward fairness. Georgetown recommends that such channeling be perfected by providing legal assistance in citizen complaint filings against physicians. If that, or its functional minimum gatekeeping equivalent, were adopted, quality assurance ought also to be aided. The U.S. Office of Technology Assessment (OTA) has designated medical negligence incidents as a weak indicator of health care quality. It has designated medical discipline as a strong indicator. The Model Act's basic provisions incorporate many of OTA's observations. See U.S. Congress, Office of Technology Assessment. (1988). Disciplinary actions, sanctions, and malpractice compensation. In *The quality of medical care: information for consumers,* pp. 121–141. Washington, DC: U.S. Government Printing Office. [This overview study suggested that a large number of poor quality physicians are not identified or penalized. Pointing to the ineffectiveness of the existing system to identify those individuals providing poor quality care, it also stated that currently only a small percentage of disciplinary actions are based on incompetence, which is the ground that would most clearly indicate poor quality of care.]

29. Federal reporting requirements for claims under the Health Care Quality Improvement Act of 1986 through a medical liability clearinghouse began operation September 1, 1990, under authority of the clearinghouse provisions described in *Federal Register.* (1989). *54,* 42722–42734.

30. See Symposium: taking medical malpractice out of the courts (1990, July). *Courts, Health Science & the Law, 1,* No. 1. The papers were prepared by Randall R. Bovbjerg (consumer perspective), "Reforming a proposed tort reform: improving on the American Medical Association's proposed administrative tribunal for medical malpractice"; Mary Ann Baily (health economics perspective), "The administrative approach to medical malpractice disputes"; Laura L. Morlock (tort reform perspective), "An assessment of potential impact on claims resolution and the quality of medical care"; and J. Douglas Peters (plaintiff's perspective), "Critique of the American Medical Association's Model Medical Liability and Practices Reform Act." The commissioned authors presented the papers at a meeting of the project's Advisory Committee. For a summary of the Advisory Committee's discussions, see Turpin, S. D., Symposial papers deliberation: stakeholders evaluate a proposed administrative alternative for medical malpractice disputes, at 46.

31. For the Wisconsin workers' compensation case study, interviews were conducted with Greg Frigo, Administrator, Wisconsin Workers' Compensation Division; David Bitter, Assistant to the Administrator; Helen Schott, Head of Administrative Law Judges; Jim O'Malley, Administrative Law Judge; Jim Pflasterer, General Counsel, Labor and Industry Review Commission; Bill Cassel, Labor and Industry Review Commission attorney; Diane Ramthun, former administrative law judge; John Neal, plaintiffs' attorney; and Tom Gorder, defense attorney; as well as numerous clerical and support personnel from the Wisconsin Workers' Compensation Division.

32. Deleted in proof.

33. Deleted in proof.

34. Deleted in proof.

35. Deleted in proof.

36. Deleted in proof.

37. These surveys were presented in *Insight into Courts.* (1990, April and June). *1,* Nos. 1 and 2. Aspects also were presented in *Courts' Corner.* (1990, July). *Courts, Health Science & the Law,* at 141–142.

38. See Note, supra note 20.

39. See Blendon, R. J., Leitman, R., Morrison, I., & Donelan, K. (1990, Summer). Satisfaction with health systems in ten nations. *Health Affairs, 9,* No. 2.

40. See Hale, J. P., & Ahlstrand, S. (1990, January). *General public opinion survey conducted for the American Society of Cataract and Refractive Surgery.* Lincoln, Nebraska: The Gallup Organization, Inc., Association Research Group.

41. Georgetown University expresses our thanks to Professor Thomas Metzloff, Duke University Law School, for suggestions and assistance in drafting and interpreting this report section.

42. Dalkey, N., et al. (1972). *Studies in the quality of life.* Cambridge, MA: Lexington Books.

43. U.S. Congress, Office of Technology Assessment, supra note 28.

44. U.S. General Accounting Office. (1990, December). *Medical malpractice: few claims resolved through Michigan's voluntary arbitration program.* GAO/HRD-91-38.

45. U.S. General Accounting Office. (1987, April). *Medical malpractice: characteristics of claims closed in 1984.* GAO/HRD-87-55. Washington, DC. GAO has estimated that the average disposition time of a medical malpractice claim in the tort system in 1984 was 25.1 months. GAO also found, using a random sample of malpractice claims filed in 1984 by 25 insurers (selected from a universe of 102 insurers representing every state and the District of Columbia, closing an estimated 73,294 claims), that the *median* disposition time was 19 months. The median disposition time for claims with an eventual payment of over $1 million was 76 months. Id. at 33.

46. See Program for Science and Law. (1990, March). Working paper: time and cost estimates. Washington, DC: Georgetown University, unpublished. See also Model Act, supra note 1, §202–211. Organized medicine's Model Act prescribed elapsed time limitations for some steps in the claims adjudicating mechanism and was silent as to others. Where it was silent,

Georgetown made estimates depending on the complexity of the case, through consultation with various experts in the field.

47. Jernigan, C. G. (1990). Step-flow diagrams of proposed medical malpractice adjudication and civil litigation. *Courts Health Science & the Law, 1*, 121–140.
48. Linde, A. E. (1990) *Arbitrating high stakes cases: an evaluation of court-annexed arbitration in the U.S. District Court.* Santa Monica, CA: Rand Institute for Civil Justice.
49. Working paper, supra note 46.
50. In Virginia, for example, pretrial screening panels were intended to eliminate litigation, according to a law journal article marking the reform's decennial anniversary. Settlement rates were not affected by a decade's experience, continuing at 90 to 95% of medical negligence cases filed in Virginia courts. See Daughtry, W. H., Jr., & Smith, C. H. (1985). Medical malpractice review panel in operation in Virginia. *University of Richmond Law Review, 19*, 272–298.
51. *Report of the Federal Courts Study Committee.* (1990, April 2). Philadelphia: U.S. Circuit Court of Appeals for the Third Circuit.
52. Marvell, T. (1987, October–November). Caseload growth—past and future trends. *Judicature, 71*, 151–161.
53. Zweig, F. M., Thurston, S. S., Turpin, S. D., Judge, D. C., Jernigan, C. G., Melnick, D. M., & Dougherty, C. A. (1990, April–May). Securing the future for America's state courts. *Judicature, 73*, 296–306.
54. The Conference on the Future and the Courts was held May 18–22, 1990, in San Antonio, Texas. Trends, scenarios, visions, and strategic plans were advanced by 380 invited participants over a 5-day period. Written summaries will shortly appear. Medical negligence and health care quality issues generally ranked in the upper quartile of expert opinions regarding the justice system's future. See, Zweig, supra note 53. Persons interested in the entire sweep of the conference may contact Dr. James Dator, the Conference's reporter, through the State Justice Institute, 120 S. Fairfax Street, Alexandria, Virginia 22314, (703) 684-6100.
55 Because most states do not routinely separate medical tort filings statistics from other torts or other civil actions, Georgetown asked the National Center for State Courts (NCSC) to cull its statistical system for those states that maintained such statistical distinctions. NCSC provided study staff with the following filing volume for selected states for calendar 1987: Arizona (Superior Court), 369; Connecticut (Superior Court), 512; Florida (Circuit Court), 1,813; Maine (Superior Court), 98; Massachusetts (Trial Court of the Commonwealth), 747; Minnesota (District Court), 377; New York (Supreme and County Courts), 7,926; North Dakota (District Court), 42. Georgetown then selected as its "typical" annual filings volume 750 cases as one element for agency cost calculations. Georgetown University extends its gratitude to Eugene Frango, assistant research director, National Center for State Courts, for his helpfulness and courtesy. Similar procedures were used to estimate a "typical" complaint volume against physicians. After reviewing state-by-state statistics, Georgetown assumed that the "typical" volume for purposes of the cost estimation for a proposed Medical Practices Review Board numbered 250 per year. The complaint volume assumption is based on the estimates of the Federation of State Medical Boards that, as a national average, one complaint is filed for every 40 physicians in the U.S. annually.
56. Georgetown staff estimated in several assessment project working papers that if a state were to pay attorneys at a rate of $90.00 per hour, legal fees alone could cost $10 million per year in a state with 750 new claims per year.
57. Georgetown estimated that, in a "low cost agency" (with a total annual expenditure of nearly $2 million) and in a "cadillac agency" (with a total annual expenditure of $7 million), the staff attorney annual costs would range between $423,000 and $2,722,500 for 15 and 25 lawyers, respectively. See Adjudication versus litigation: costs to state government. (1990, June). *Insight into Courts, 1*, No. 2, Table 3, "Organization cost estimates for model act implementation (in 1989 dollars)," at 6.
58. Cost assumptions for the administrative agency's estimates are published. See *Insight into Courts.* (1990, June). *1*, No. 2, p. 6. Customary and typical cost centers were attributed to the agency, and totals were assumed to represent annual operating costs. These totals generally found corroboration in budgetary characteristics of Maryland's Health Claims Arbitration Office and Bureau of Medical Quality Assurance. See Thurston, S. S. (1990). Medical malpractice dispute resolution in Maryland. *Courts, Health Science & the Law, 1*, 81–86. Budget and audit histories of the Wisconsin Division of Workers' Compensation and the Wisconsin Securities Commission also corroborate the ballpark utility of Georgetown's cost estimates. For example, for staff of a size and composition comparable to the proposed Medical Practices Review Board, Wisconsin's workers' compensation annual budget in 1988 was $4.2 million; see U.S. Department of Labor (1990). Workers compensation agency information: a state-by-state comparison, unpublished. Georgetown's estimates range from $2 to $7 million for the proposed new medical practice agency. The extremes represent a "low cost" and a "high cost" alternative, respectively.
59. (Maryland) Thurston, supra note 58, at 81; (Virginia) Klaidman, S. (1990). Medical malpractice in Virginia. *Courts, Health Science & the Law, 1*, 75–80; (Michigan) Thurston, S. (1990) Medical tort reform: the Michigan case. *Courts, Health Science & the Law, 1*, 263–271.
60. Caruso, supra note 28.
61. Morlock, supra note 30.
62. Michigan, for example, has offered claimants the option of electing mandatory binding arbitration for medical negligence claims, and as noted in note 27, the arbitration act was tied up in litigation for 9 years before the Michigan Supreme Court finally declared it to be constitutional. During the period of uncertainty, very few cases elected arbitration. Presently, about 6.2% of the medical negligence cases in Michigan elect arbitration; the larger cases tend not to elect arbitration. See Applied Social Research, Inc. (1983, October). Evaluation of Michigan Medical Malpractice Arbitration Program. Likewise, in Maryland, the Health Claims Arbitration Act [establishing mandatory non-binding arbitration] was passed in 1977 and declared constitutional in 1978. In 1977, only two cases were filed at all; the next year, 93 cases were filed. Case filings peaked at 749 in 1986 and have leveled off to about 500 per year. See Thurston, supra note 59.
63. U.S. General Accounting Office, supra note 44.
64. It might be possible to experiment with the jury system, but current system proponents might more strongly object to such innovation as a direct constitutional assault than that posed by the pilot test of an administrative alternative. See Pendell, J. W. (1989). Enhancing juror effectiveness: an insuror's perspective. *Law & Contemporary Problems, 52*, 311.
65. See *Public attitudes toward the civil justice system and tort law reform,* study no. 864014. (1987, March). New York: Louis Harris and Associates, Inc. [A survey of almost 2,130 adult Americans showed that almost 9 of 10 Americans want changes in the civil justice system. The Harris report on this survey stated, "what most of the public currently demands is greater efficiency at a lower cost to both individuals and society."] See also Swickard, J. (1986, August 7). Survey finds most feel justice is costly, complex. *Detroit Michigan Free Press.*
66. Georgetown's research staff is grateful to Professor Thomas Metzloff for the articulation of this dilemma. The following observation extends themes begun in his earlier, important article. See Metzloff, supra note 7.
67. For a useful, albeit dated survey of challenges to extrajudicial arbitration of health care injury claims, for example, see Sanders, L. K. (1986, Winter). The quest for balance: public policy and due process in medical malpractice arbitration agreements. *Harvard Journal on Legislation, 23*, 266–285. Challenges may be raised against entry of all extrajudicial organizations. In Maryland, for example, the Health Claims Arbitration Office, an executive branch agency, weathered a series of such challenges. See Thurston, supra note 58.
68. Inspector General, supra note 28.

69. Caruso and Fellmeth, supra note 28.
70. Jernigan, supra note 47.
71. Organized medicine's proposal, supra note 1, p. 14, states that "in making this proposal, we are not breaking new ground. State legislatures abolished the common law cause of action for personal injury in the workplace just after the turn of the century. In its place, states enacted workers' compensation schemes—based upon a quid pro quo deemed to serve all parties' interests." See infra note 72.
72. A recent Virginia case, Roller v. Basic Construction Co., —— — VA ———, 384 SE 2nd 323, 325 (1989), explained the quid pro quo as follows: "As frequently stated, the Workers' Compensation Act is based upon a quid pro quo, a societal exchange wherein employees are provided a purely statutory form of compensation for industrial injuries. The remedy is modest, but relatively certain. Claimants are free from the necessity of proving negligence and resisting such affirmative defenses as contributory negligence and assumption of risk. In exchange, employers under the canopy of the Act are sheltered from common-law liability in tort."
73. For a discussion of constitutional issues in workers' compensation cases, see generally Cudahy Packing Co. v. Parramore, 263 US 418, 44 SCt., 153, 68 LEd. 366 (1923); Arizona Employers' Liability Cases, 250 US 400, 39 SCt. 553, 63 LEd. 1058 (1919); Jensen v. Southern Pacific Co., 215 NY 514, 109 NE 600 (1915), reversed on other grounds 244 US 205, 37 SCt. 524, 61 LEd. 1086 (1917). Also see Boden, L. I. (1988, December). Reducing litigation: evidence from Wisconsin (WC 88 7). Cambridge, MA: Workers' Compensation Research Institute.
74. See, for example, Kladiva, S. D. (1988, Spring). The clash over medical malpractice. *GAO Journal, 1*, 48–54 [She states that policy makers will not be successful in enacting malpractice legislation and reforms until the problems of inadequate data, conflicting objectives of the parties, and the crisis environment in which malpractice reform is attempted are alleviated; see also Sloan & Bovbjerg, supra note 20, at 45. [They predict a possible liability crisis in the not too distant future and encourage policy makers to react as part of a reasoned approach to compensating and deterring injuries, not in a crisis management style.]
75. Learner, H. A. (1981, Winter). Restrictive medical malpractice compensation schemes: a constitutional "quid pro quo" analysis to safeguard individual liberties. *Harvard Journal on Legislation, 18*, 143–206. [The author argues that utilizing the intermediate level of scrutiny to examine the constitutional integrity of restrictive medical malpractice compensation schemes is inadequate and that the same quid pro quo analysis utilized in workers' compensation schemes should be utilized instead.]
76. Gurtler, P. R. (1989, Fall). The workers' compensation principle: a historical abstract of the nature of workers compensation. *Hamline Journal of Public Law and Policy, 9*, 285–296. See also Larson (1952). The nature and origin of workers' compensation. *Cornell Law Quarterly, 37*, 206; Hood, J. B. & Hardy, B. A., Jr. (1984). *Workers compensation and employee protection laws: theories and policies of workers' compensation*. pp. [illegible]. St. Paul, MN: West Publishing Co.; King, J. R., Jr. (1988). The exclusiveness of an employee's workers' compensation remedy against his employer. *Tennessee Law Review, 55*, 407. Bale, A. (1989, Winter) The enactment of the state workers' compensation laws in American legal studies. *Legal Studies Forum, [illegible]* 49–73.
77. The fault context is believed by organized medicine to retain the profession's historical and ethical responsibility for patient care. No-fault systems would likely be easier to sustain constitutionally, and Reynolds and co-authors do not try to discredit them even though jury trial is unavailable. For many observers no-fault uses an economic approach that considers the cost of accident prevention and the cost of the harm. The moral connotation of fault is eliminated, but so is the responsibility for professional action. The economic theory is presented in Judge Learned Hand's famous case, TJ Hooper 60 F2nd 737 (1932). The practice of health care provision goes beyond such theories, however, and affects real people proximately and profoundly.
78. U.S. General Accounting Office, supra note 44.
79. *Report of the Federal Courts Study Committee*, supra note [illegible].
80. Id. at 18–19.
81. Id.
82. See Zweig, et al., supra note 53.
83. Id. at 303.
84. Bovbjerg, supra note 3.
85. Inspector General, supra note 25.
86. *Federal Register*, supra note 29.
87. Georgetown's research staff is grateful to Professor Thomas Metzloff for the articulation of this observation.

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EXECUTIVE SUMMARY

Georgetown University undertook between 1989 and 1991 six small-scale studies to illuminate organized medicine's proposal for a new fault-based administrative agency at the state level to adjucate medical negligence claims and relate such adjudication to medical professional oversight.

The key element in this proposal is the creation of a "Medical Review Board" appointed by the Governor with the concurrence of the state legislature. This Board would replace common law courts as an exclusive, mandatory remedy for health care consumers who believe they have a claim against a health care provider. A primary objective is to provide claimant access to a predictable, prompt, expert system of dispute resolution and compensation. Its primary means to achieve that objective is free, guaranteed legal representation furnished claimants by the proposed Board. Once the various steps in this proposed system are exhausted, an appeal is available to a state appellate court, but the latter's jurisdiction would be confined to a determination of whether the Board adhered to the rules and not whether the decision was correct.

The mini-studies undertaken by Georgetown were intended to answers several questions raised with respect to organized medicine's proposal. The fairness and efficiency of the proposed administrative system when compared with the current system of civil litigation has been posed as a principal question. Its cost and ability to marshall scientific evidence effectively

was also questioned. A final inquiry is the utility of workers' compensation agencies as an adjudication prototype.

The results of studies led Georgetown to conclude that the new institution proposed by organized medicine could be as fair and would be more efficient than the system of current litigation. Moreover, it has the potential to improve health care quality generally through linkage of medical negligence adjudication and professional discipline. A summary of the mini-study findings follows below.

Fairness

Organized medicine's proposal would enhance fairness for plaintiffs in the resolution of medical negligence disputes even though the proposed new administrative agency would dispense with jury trials. Fairness would be enhanced in large part from the provision of free legal representation built into the proposed new institution. A major problem facing health care consumers is blocked access to the legal system, especially for persons having meritorious small claims, i.e., those under $100,000. The new administrative agency would provide such access. To assure both fairness and its perception, Georgetown recommends that organized medicine's proposal assist claimants in the initial preparation of a claim and that the agency's staff lawyers be insulated from chain of command requirements that typically are a part of administrative schemes. There is every reason to believe that such minor amendments could easily be made.

Time and Cost

Georgetown's mini-studies disclosed that as much as half the time currently required to resolve medical negligence disputes would be required for administrative adjudication of typical claims. For claims of profound and severe medical injury, the administrative agency would require approximately 20% less time than currently experienced on average in the civil justice system.

Costs

Georgetown found that the cost to the public of maintaining a forum for medical negligence adjudication would be approximately 25% less per case than the cost of operating the courts in such cases. At the same time, such reduced costs permit payment of free legal representation to claimants. Thus, it was concluded that a fault-based administrative agency could be one of the best public policy "bargains" to emerge in the health field.

Georgetown also concluded, from studies of state medical board financing and operation, that a fault-based administrative agency could be operated at approximately the same cost level requirements as medical credentialing and disciplinary agencies.

Expert Opinion

One of the mini-studies conducted in the Georgetown review was a "Delphi" study of 29 experts representing the entire spectrum of plaintiff and defendant orientations. This mini-study asked for elaborate written responses to organized medicine's proposal. The written response was followed by a lengthy personal interview.

The 29 experts determined that the administrative agency, in their opinion, would be more efficient than the current system. They also concluded by a majority opinion, 60% to 40%, that it would be less fair, although the basis for fairness, aside from abolition of jury trials, was unclear.

The experts believed that a demonstration test of organized medicine's proposal should be conducted. Nineteen states were suggested as possible candidate test sites.

Judicial and Court-Related Opinion

In several separate surveys of judges and court-related personnel, opinion about the desirability of organized medicine's central premise was evenly divided into thirds. When asked whether medical negligence cases should be relocated to an administrative agency with guaranteed claimant legal representation, one-third favored the idea, one-third opposed it, and one-third were neutral.

In view of the strong trend set by the Federal Courts Study Committee to promote experimentation with dispute resolution, the environment for organized medicine's proposal seems to be considerably more favorable for a pilot test than at any time in the past.

The Workers' Compensation Analogy

Georgetown undertook a thorough study of the workers' compensation agency in Wisconsin, generally considered to be among the best of such operations in the United States. Organized medicine had proposed that the new fault-based administrative agency would be modeled after workers' compensation agencies. Georgetown found that the workers' compensation system is a useful analogy; it is an efficient and fair mechanism; and it enjoys widespread support in that state. Private attorneys in the program are willing to accept the 20% of claimant cap imposed upon claimant awards in exchange for caseload volume, one feature of organized medicine's omnibus proposal as regards permissive retention of private counsel by claimants.

Unexplored Issues and Suggested Improvements

The constitutional implications of shifting adjudication to administrative experts from a jury trial forum—from Article III to Article I courts—remain unexplored. It may be that real access to an authoritative dispute resolution system for the 7 out of 8 medically injured people with relatively small claims, who are currently locked out of the courts, is the necessary quid pro quo to achieve that shift.

The centerpiece of that access is universal, free legal representation, provided as a right to anyone with a claim against a health care provider. To foster access, organized medicine should consider providing such representation from the time a person drafts a claim, not from the time, as currently proposed, a claim is certified as meritorious. Moreover, the plaintiff's bar should be brought into an experimental design, perhaps with cases allocated on a lottery basis, and outcomes should be compared with cases handled by Board-employed attorneys.

Organized medicine's new institutional design promises many advantages leading to improved health care quality. Its built-in connection of adjudication and professional performance oversight is one such advantage.

The proposal may well be a way to go beyond a truce and to bring collaboration between medicine and justice.

Appendix D

The AMA Response

The AMA together with the more than thirty national medical specialty organizations which participate in the AMA/Specialty Society Medical Liability Project, is actively working to further the goal of patient safety. Among its purposes, the AMA/SSMLP is dedicated to furthering innovation in the loss prevention field and has a standing Patient Safety/Risk Management Subcommittee. Through this Subcommittee, the AMA/SSMLP monitors patient safety initiatives and disseminates information to hospitals, medical societies, insurers and others to promote the exchange of ideas and approaches.

The AMA/SSMLP also has undertaken development of several practical risk management tools. In 1988, it published, together with the PIAA, the Compendium of Patient Safety and Medical Risk Management Programs, a 160 page catalog of the risk management activities of state and national medical societies, insurers and others, complete with subject matter index and the identities of key contact people to facilitate networking among professionals across the country.

This initial contribution was followed with a document entitled Principles and Commentaries on Risk Management for the Medical Office. Developed in consultation with nationally known experts, the publication sets forth in twelve chapters pragmatic risk management advice primarily for office-based practices. The chapters cover such topics as obtaining informed consent, establishing good communication with patients, developing workable follow-up systems for responding to patient telephone calls and missed appointments, instituting schedules for the maintenance and calibration of equipment and evaluating the safety of office and parking area grounds, among others. (Copies have been provided to the Subcommittee members.)

The AMA/SSMLP also is implementing an integrated risk management program that already has been pilot tested in Oregon. Based on principles of continuous quality improvement, the program's two-fold purpose is to offer risk prevention advice and collect data to be used as a continuous feedback mechanism on the effectiveness of loss prevention efforts. The program consists of an office self-assessment survey, a self-study course and an office site visit and assessment by a professional risk manager -- which together constitute a single learning process that is adaptable to any specialty.

In addition to these activities, in January of this year the AMA published a risk management resource book developed for residents and young physicians that was developed in conjunction with the Harvard Risk Management Foundation. Entitled Grand Rounds on Medical Malpractice, the text is now being used by the Harvard Medical School, and is also available as a CME risk management course for practicing physicians.

These targeted injury prevention efforts represent only a few of the many activities undertaken by the Maine Medical Association, the AMA and

others to continually improve the quality of medical care. In 1986, the AMA began a major initiative to expand its traditional leadership and reaffirm the profession's commitment to self-regulation. As part of this initiative, the AMA established in 1987 a new Office of Quality Assurance to promote the development of practice parameters that address effective clinical practice and appropriate utilization. The AMA's quality assurance activities are outlined in the Association's Health Access America proposal.

Most recently, the AMA has initiated a program to review its membership on a continuing basis and withdraw the privilege of membership from those physicians who have been found to be incompetent or unethical. In January, 1990, a commitment was made to assist any state or county medical society to take similar action. This commitment includes providing guidance on the appropriate procedural steps and safeguards that must be followed, and paying the litigation expenses incurred by medical societies or their members in discharging this responsibility -- a factor that has chilled action of this nature in the past.

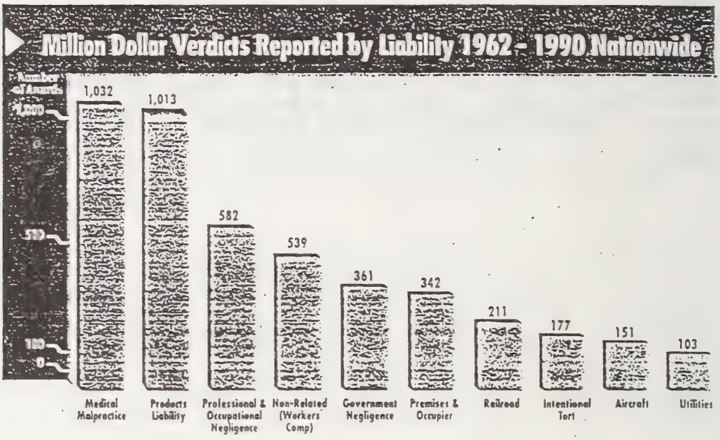
We recognize that this latest action does not eliminate the danger posed by the small population of aberrant practitioners that threaten the safety of their patients. We offer it as one more affirmative step in a continually expanding effort to minimize this danger wherever possible.

5066s

Figure 1

Why the California Legislature Singled Out Medical Malpractice For Reform

Medical malpractice was singled out by the California Legislature for special treatment in the law because nationwide there are more million-dollar-plus awards for this form of liability than for any other non-vehicular liability exposure.

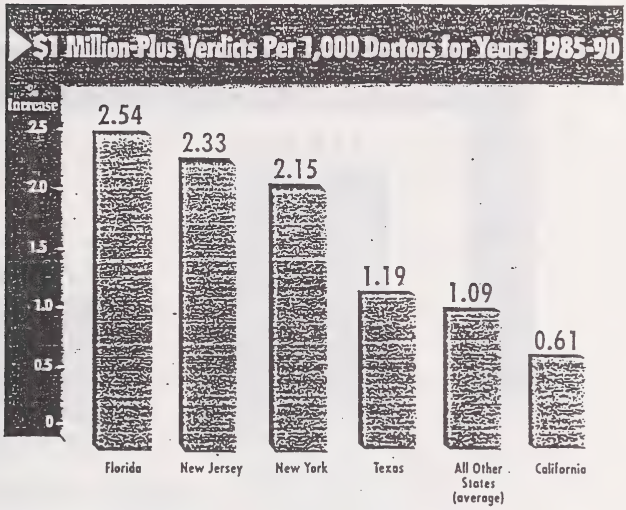


SOURCE: Jury Verdict Research — Nationwide Statistics

Figure 2

MICRA Works in California

Because of MICRA's $250,000 cap on awards for non-economic losses and its limits on attorney contingency fees, the number of million-dollar-plus malpractice awards is substantially lower in California than in states that have failed to enact MICRA-like reforms — lower even than the average of all other states.



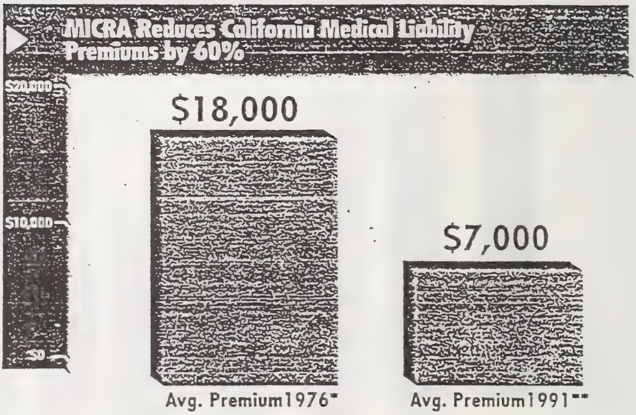
SOURCE: Jury Verdict Research

Figure 3

Insurance Premiums Cut

MICRA Has Cut Medical Liability Insurance Premiums by 60%

Before MICRA took full effect, California physicians paid an average $18,000 for liability insurance in 1976. By 1991, MICRA had reduced the average liability premium to $7,000 — a 60% savings.



— Shown in 1991 dollars

* $7,241 average premium adjusted to 1991 dollars on the December Urban CPI Index

** Dividends from 1990 deducted from 1991 average premium

SOURCE: Physicians Insurance Association of America

Figure 4

National
Medical Liability
Reform Coalition

1700 K Street, NW, Suite 906
Washington, DC 20006
Telephone (202) 296-7686
Fax (202) 466-4346

MEDICAL LIABILITY INSURANCE COSTS

	Arizona Eff. April 1, 1991 Entire State	California Eff. January 1, 1991 L.A. area (4 counties)	Florida Eff. January 1, 1991 Miami area (2 counties)	Illinois Eff. July 1, 1991 Chicago area (9 counties)	Michigan Eff. July 1, 1991 Detroit area (3 counties)	New York Eff. July 1, 1991 Long Island area (2 counties)	Texas Eff. January 1, 1991 Houston area (5 counties)
Anesthesia	$32,000	$12,300	$48,200	$23,000	$47,500	$34,500	$29,000
Cardiovascular surgery	$22,400	$38,000	$110,900	$49,200	$71,300	$65,100	$46,600
Family practice/ Minor surgery, no Ob	$15,400	$8,400	$32,600	$9,900	$34,800	$13,200	$23,200
Family practice/ Major surgery, w/Ob	$29,300	$18,700	$149,500	$20,200	$71,300	$23,400	$32,700
Neurosurgery	$73,900	$51,400	$183,300	$69,700	$154,500	$118,100	$47,900
Obstetrics/ Gynecology	$52,900	$38,000	$149,500	$49,200	$133,900	$101,200	$55,900
Orthopedic surgery	$36,300	$32,300	$110,900	$61,300	$133,900	$89,600	$49,300

1. These costs reflect a typical mature claims made policy of $1 million/$3 million.

2. Please note: These figures are approximates (rounding to the nearest $100) due to restrictions from the industry.

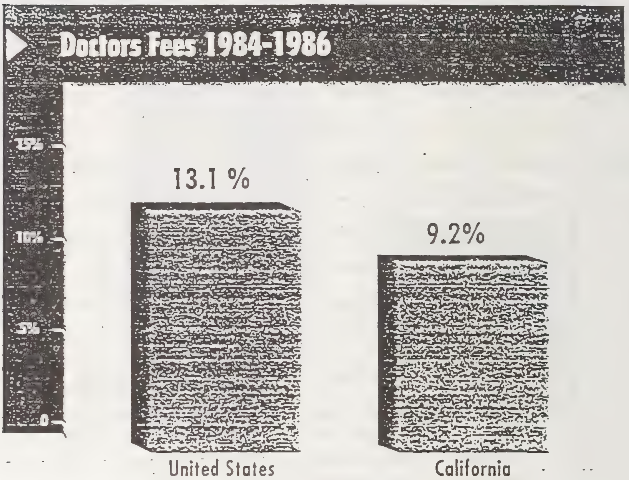
The National Medical Liability Reform Coalition is a broad-based group of organizations gathered for the purpose of promoting medical liability reform as a key element of health care reform.

Figure 5

MICRA Helps Keep Californians' Medical Bills in Check

Without MICRA, Doctors' Fees Would Be Higher

From 1984 to 1986, doctor fees nationwide increased 13.1% — but only 9.2% in California. If California doctor fees had increased at the national rate during this period, the added costs to California consumers would have been $790 million.



*Note: MICRA was upheld by the California Supreme Court in 1984-85

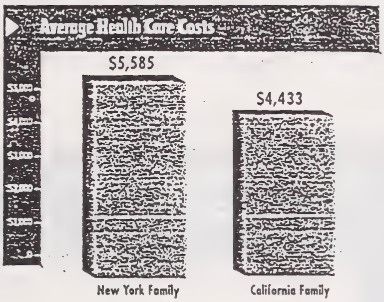
SOURCE: American Medical Association

Figure 6

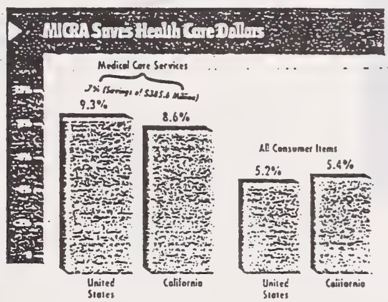
After MICRA: Real Results

MICRA Helps Control Medical Costs in California — Without MICRA, Medical Costs Would Be Even Higher

By controlling the cost of liability insurance, MICRA has slowed the increase of health care costs in California. As illustrated in the first chart, a recent consumer study by "Families USA" shows that health care costs for the average New York family in 1991 were $5,585 — compared to $4,433 for the average California family.



Further, as seen in the second chart, although consumer costs in California generally were higher than the national average in 1991, the state's medical care services index was lower. In 1991, California's medical costs increased less than medical costs for the nation as a whole, saving Californians $385.6 million.



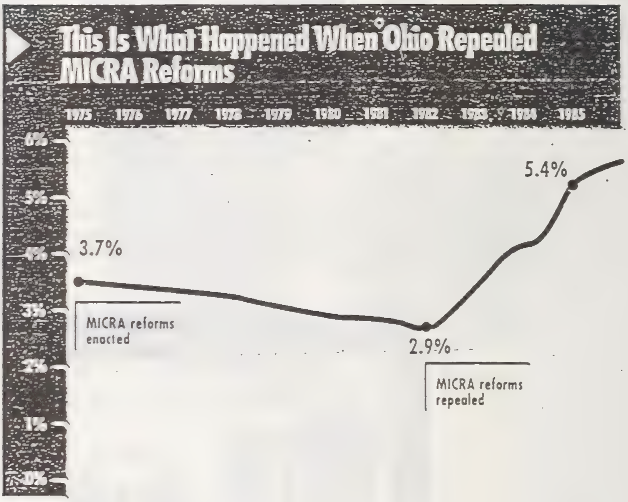
SOURCE: 1. Families USA
2. Source: Consumer Price Index for All Urban Consumers [illegible]

Figure 7

Effect of the $250,000 CAP on Non-Economic Damages

Ohio Professional Liability Payments as a Percent of Payments Nationwide

Ohio adopted MICRA reforms in 1975, when payment of medical malpractice claims in the state of Ohio was 3.7% of the total paid out nationwide. That percentage declined to 2.9% from 1975 to 1982 while the reforms were in force. In 1982, the Ohio Supreme Court invalidated the $250,000 cap on pain and suffering, and by 1985 Ohio's percentage of nationwide claims had climbed to 5.4%



SOURCE:

Figure 8

Number of Claims and Compensation for Noneconomic Losses by Size of Noneconomic Losses

Dollars in millions

Noneconomic loss compensation ranges	Paid claims[a]		Aggregate compensation for noneconomic loss[a]
	Number	Percent	
$0	3,603	24.0	$0.0
$1 to $50,000	10,023	66.8	105.4
$50,001 to $200,000	1,049	7.0	107.6
More than $200,000	321	2.1	342.4
Total	14,995	100.0	$555.3

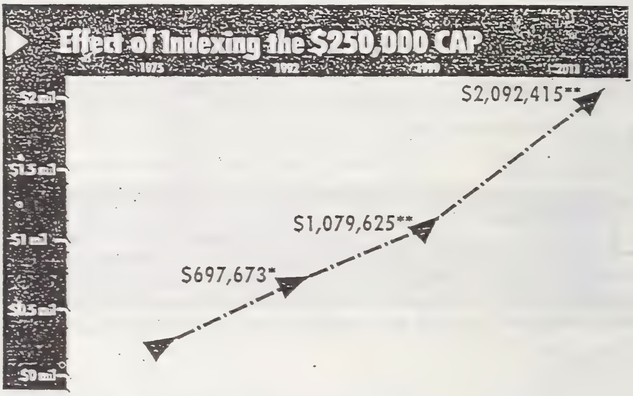
[a]Detail does not add to total due to rounding.

Note: Claims classified by noneconomic loss compensation ranges only represent paid claims for which data were provided and, therefore, are representative of about half of all paid claims.

Figure 9

Effect of Indexing the $250,000 CAP

Index the $250,000 cap back to 1975, and it would raise the cap to $700,000 today. Based on average increases in the CPI over the past 16 years, the cap would then double every ten years, sending the cap spiralling out of control, eliminating its effectiveness in stabilizing liability and health care costs.



* based on actual changes in CPI

** based on average of actual CPI 1975-1992 of 5.61%

SOURCE: U.S. Department of Labor

Figure 10

The Global Perspective

A Twelve-Country Comparison

Comparing U.S. tort costs to the cost of other countries' tort systems is complicated by differences in the available data. As with our estimate of U.S. costs, our research on tort cost trends in other countries is based largely on insurance industry data, augmented by estimates of uninsured or self-insured costs. But while our methodology for estimating U.S. and foreign cost trends is similar, the available data on foreign costs are limited. Hence, our historical database on foreign tort trends goes back only to the 1960s or 1970s.

Moreover, the sources of foreign data tend to change over time and geography, sometimes requiring reconciliation and greater estimation than does the U.S. data compiled by A.M. Best. Finally, we were unable to find any studies on the amount of self-insurance of foreign tort costs and our estimates are fairly crude, relying by necessity on interviews with international insurance and risk management experts in the various countries studied. As a result, our foreign cost estimates are subject to greater margins of error than the U.S. figures. Our best guess is that the foreign figures are subject to errors of estimation of 15% to 20%, compared to about 10% for the U.S. data.

But even allowing for this level of possible error, the cost of the U.S. tort system is substantially higher than that of any other country studied, and two and one-half times the average.

Global View: Tort Costs as a Percentage of GDP (1991)

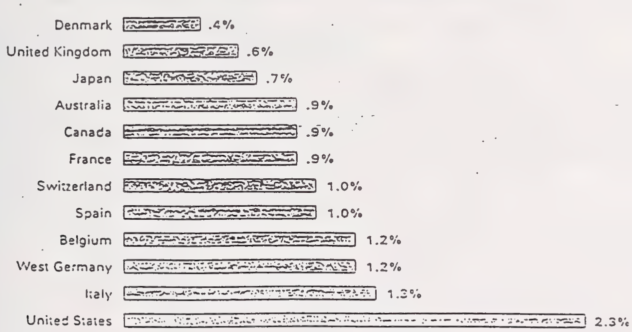


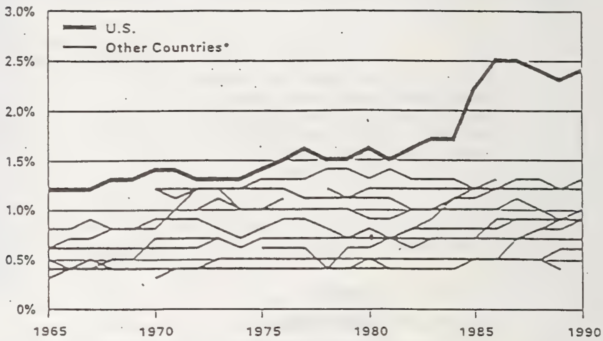
Figure 11

The Global Perspective

1965–1990

Perhaps the most striking thing about tort costs in other major countries is their lack of relative growth, compared with the U.S. cost spiral. The following graph tells the story.

International Tort Cost Trends
As a Percentage of GDP



* See Figure 10

STATEMENT OF JOHN D. LEECH, MEMBER, BOARD OF TRUSTEES, AMERICAN HOSPITAL ASSOCIATION

Mr. LEECH. Mr. Chairman, my name is John D. Leech, and I am accompanied here by the Washington counsel of the American Hospital Association. I am a practicing health care attorney with the Cleveland-based law firm, Calfee, Halter & Griswold, and I am also a member of the board of trustees of the American Hospital Association.

On behalf of AHA's approximately 5,300 institutional members, I am pleased to testify on our view of reforming the current medical liability system.

This country is on the verge of comprehensive health care reform. AHA envisions a health care system based on networks of providers furnishing care at the community level. One element of our health care system that must be addressed, however, if reform is to be successful, is the reform of our medical liability compensation system.

The AHA, along with other organizations, believes that the medical liability compensation system currently fails to meet its own goals of adequately and fairly compensating injured patients, and at the same time, effectively deterring bad health care practices.

Many of our health care providers are afraid to practice their trade because of anticipated liability claims and, as a result, resort to defensive medicine, overprescription of tests by providers, et cetera.

Many providers are unwilling to practice in their specialty areas such as obstetrics and emergency room care because of increased malpractice premiums and the threats of unfounded lawsuits. As a result, many communities are left underserved with little or no access to appropriate health care services.

People injured by poor quality of care are entitled to fair and prompt compensation for their injuries, but our present system costs far too much and works much too slowly, and fails to provide fair compensation to most patients injured by medical malpractice, while providing exorbitant lottery-type awards to others.

The current system fails to promote quality health care. As well, it adds billions of dollars annually to the national health care bill. AHA believes a comprehensive health system reform proposal should include: One, patient safety reform through continuous quality management; two, exploring the use of an alternative dispute resolution mechanism; three, the creation of guidelines for treatment by physicians and hospitals; and finally and probably most importantly, federally mandated uniform standards for medical liability to be applied equally in all 50 States and which would preempt the State laws.

AHA endorses certain specific medical liability principles that we view as essential, not only to reforming the medical liability system, but as a key to reforming the health care delivery system as well. Among these principles are the following: First, "pain and suffering," and other noneconomic damages in medical malpractice cases are higher than in all other tort verdicts. These noneconomic damages have the largest adverse financial impact on health care providers, both hospitals and physicians.

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AHA supports caps on noneconomic damages which would limit the dollar amount of damages a plaintiff may be awarded. Such caps, we feel, would ensure that plaintiffs would be justly compensated for damages incurred while preventing runaway lottery-type awards for noneconomic damages.

Second, the collateral source rule prohibits courts from taking into account the fact that part of many plaintiffs' expenses are already covered by health insurance, disability compensation or income protection insurance. Studies have estimated that the elimination of this collateral source rule would reduce malpractice premiums by as much as 15 percent. AHA strongly supports the elimination of the collateral source rule so that double recoveries just don't occur.

Third, AHA supports caps or limitation on plaintiffs' attorneys fees. We feel such a change would allow injured plaintiffs to actually receive a greater proportion of any recovery.

Fourth, AHA supports requiring periodic payments of damages in medical malpractice cases.

Fifth, AHA support, abolition of the joint and several liability rule so that damages would be fairly apportioned among defendants based on negligence not on wealth.

Finally, there is the issue of enterprise liability. AHA is interested in gaining a better understanding of enterprise liability and how it would be applied to a network or accountable health plan, as well as whether it would meet the goals of medical liability reform. However, enterprise liability clearly cannot be applied to the current health care system and a number of very significant issues need to be resolved before it could be adopted.

In conclusion, AHA strongly supports reforming the entire health care delivery system and we have taken an active part in working toward that end. AHA also strongly believes that medical liability reform should be an integral part of this process.

AHA also feels that medical liability problems can only be adequately and equitably addressed by providing a Federal solution. AHA believes that billions of dollars in health care savings, as well as enhanced access to care, can be achieved by changing the medical liability laws as we have suggested in our written statement.

I would be pleased to answer any questions any members of the subcommittee may have.

Thank you, Mr. Chairman.

Chairman STARK. Thank you.

[The prepared statement and attachments follow:]

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Statement
of the
American Hospital Association
before the
Ways and Means Committee,
Subcommittee on Health
of the United States House of Representatives
on
Health Care Reform: Issues Relating to Medical Malpractice

May 20, 1993

SUMMARY

AHA strongly supports reform of our health care delivery system and development of a system founded on networks of providers delivering care at the community level. Restructuring our delivery system will entail addressing problems caused by the high cost, inefficiency, and inequity of our current medical liability compensation system. The time for medical liability reform is ripe. AHA, along with other organizations, endorse specific medical liability principles as essential for medical liability and overall health care reform.

The medical liability component of a comprehensive health care reform proposal should include: 1) patient safety reform; 2) exploration of alternative dispute resolution (ADR) mechanisms; 3) development of physician practice parameters; and 4) uniform standards for medical liability.

AHA believes that effective reform, including tort reform, will result in a more efficient and equitable distribution of health care dollars. Savings realized from reform should reduce the overall costs associated with health care spending and redistribute the savings to help deliver more cost effective, high quality care. As part of overall health care reform, a package consisting of federal tort reforms for malpractice claims, implementation of patient safety mechanisms, exploration of ADR systems, and development of effective practice guidelines would address the medical liability issue and help establish a system that compensates injured patients adequately and equitably.

Mr. Chairman, I am John Leech, a member of the American Hospital Association's (AHA) Board of Trustees. On behalf of the AHA's approximately 5,300 institutional members, I am pleased to testify on our view of reforming the current medical liability system.

This country is on the verge of comprehensive health care reform. As we move toward reform, we are faced with the challenge of finding an acceptable balance between providing greater access to health care services and conserving health care resources. To meet this challenge, we will need to restructure the way health care is delivered in the United States.

Restructuring our health delivery system will necessarily entail addressing problems caused by the high cost, inefficiency and inequity of our medical liability compensation system. The AHA, along with other organizations, believes that the current medical liability system currently fails to meet its goals of compensating injured patients and effectively deterring bad health care practices. We envision a future health care system complete with

medical liability reforms that will encourage physicians and other practitioners to practice high quality medicine without fear of unfounded liability.

Although medical liability reform has been discussed for some time, the opportunity for implementing reforms has never been riper. As we move toward comprehensive reform of our health care system, we must be sure to make medical liability reform an integral part of these efforts. Medical liability reform will further promote the delivery of quality health care for all.

THE NEED FOR CHANGE

The U.S. health care system is unique, both in its strengths and weaknesses. We have a wealth of health care facilities and highly trained personnel, and have long been recognized as a leader in the high quality of health care provided. Our health system encourages clinical innovation and is known for state-of-the-art treatments and technologies. Consequently, however, we have created unrealistic expectations which often cause patients to file lawsuits against providers when the results of treatment are less than expected.

The current medical liability system threatens access to and quality of care. Many health care providers are afraid to practice their trade because of anticipated liability claims, especially in high risk specialties such as obstetrics. Some providers are simply unwilling to practice in their specialty areas because of increasing malpractice premiums and the threat of a lawsuit. Many communities therefore are left underserved with little or no access to appropriate health care services. Consequently, patients are often left to patch together services in a variety of settings from unconnected providers or providers who are not properly trained in specialty areas. In order for providers to be willing to deliver appropriate health care services in all specialty areas, the threat and burden of malpractice must be lifted.

The current liability system for medical malpractice claims also serves to drive up the indirect costs of health care by encouraging physicians to practice "defensive" medicine. In an effort to avoid liability claims, physicians may err on the side of providing medically unnecessary services. A recent study prepared by Lewin-VHI, Inc. entitled "Estimating the Costs of Defensive Medicine" indicates that approximately $35.8 billion in savings over a five year period could be obtained by reducing the practice of defensive medicine. As the country looks for ways to reduce unnecessary health care expenditures, liability laws which encourage such spending need to be addressed.

People injured by negligent care are entitled to fair and prompt compensation for their injuries. All parties should have the right to a fair and cost-effective dispute resolution process. However, when examining the current medical liability system, it becomes apparent that the current system:

- costs far too much and works much too slowly;
- fails to provide access to the legal system or fair compensation to most patients injured by medical malpractice, while providing exorbitant awards to others;
- cannot promptly or cost-effectively identify unfounded claims;
- fails to adequately promote quality health care or protect patients from avoidable injuries;
- adds billions of dollars annually to the national health care bill in medical liability premium costs and by encouraging doctors and other medical professionals to practice "defensive medicine" as a hedge against potential lawsuits; and,
- threatens access to health care, especially higher risk services, such as obstetrics and emergency room care.

Studies on our medical liability system are in agreement that the current inefficient system adds to the problem of making quality health care services available to all Americans while effectively managing health care costs. (See, for example, General Accounting Office, Medical Malpractice: Characteristics of Claims Closed in 1984, GAO/HRD 87-55; Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation and Patient Compensation in New York (1990) (Harvard Medical Practice Study); and Saks, Michael J., "Do We Really Know Anything About the Behavior of the Tort Litigation System--and Why Not?," University of Pennsylvania Law Review, Vol. 140 (4), April 1992.)

AHA'S REFORM VISION

Insufficient access, rising costs, and fragmentation of care have led to patient dissatisfaction with the current health care system. Americans question the value they are receiving for their health care dollars. The United States has the greatest health care available in the world, but our delivery system is in desperate need of repair.

The AHA's vision for health reform calls for universal access to a basic health care benefits package. The set of basic benefits would cover the full range of services from preventive care through long term care. Universal access would be provided by means of a pluralistic system of financing -- a combination of private workplace coverage and a new public program consolidating and expanding Medicare and Medicaid. Employers would be first encouraged, and ultimately required, to provide coverage for their workers and dependents.

AHA's reform plan is founded on the concept of Community Care Networks℠, providers working together to furnish patients with integrated care organized at the community level. These networks are similar in concept to the accountable health plans, or "AHP's," often referenced in current health policy discussions. Community care networks would improve the quality of care because they hold the promise for true management of patient care. True managed care requires assessing patient health risks and needs, and planning, organizing, and delivering care so that problems are averted or treated early and all needed services are efficiently provided. To optimize the efficiencies possible from a reorganized delivery system, AHA seeks medical liability reform to reduce the unnecessary costs of the malpractice compensation system and its effect of stimulating defensive medicine.

AHA believes that comprehensive health reform must include effective medical liability reform, if cost containment and health care access objectives are to be achieved. The medical liability component of a comprehensive health system reform proposal should include:

- patient safety reform;
- alternative dispute resolution (ADR);
- practice parameters; and
- uniform standards for medical liability.

ESSENTIAL PROVISIONS FOR MEDICAL LIABILITY REFORM

I. PATIENT SAFETY REFORMS

Medical liability reform must promote patient safety and quality of care. The problem of adverse patient outcomes can be effectively addressed through continuous quality management, the strengthening of public and private systems that have the capacity to gather and analyze data relating to risk factors, and appropriate follow-up action. AHA believes that states should be required to establish mandatory patient safety programs. Licensed professionals should be required to participate at least once every three years in programs tailored to their particular profession and specialty area of practice. In addition, each liability insurer should provide or endorse risk management programs for its insured and every health

care facility or institution should be required to have in effect a risk management program.

II. ALTERNATIVE DISPUTE RESOLUTION (ADR)
Medical liability reforms must encompass more than control of damage awards and other traditional tort reforms. The current judicial system, as applied to medical malpractice claims, is inefficient, costly and renders unpredictable results. Nontraditional approaches that either remove claims resolution from the courts altogether or facilitate existing judicial procedures could play an important role in reforming the current health care system. ADR mechanisms are intended to increase patient access to the dispute resolution process and expedite the resolution of medical liability claims. The ultimate goal of ADR is to create an efficient, cost effective and predictable system for the handling of medical liability claims.

AHA supports the continued development of successful ADR programs for medical liability through federal support of state demonstration projects. These projects should evaluate the merits of ADR proposals designed to divert claims from the civil justice system and resolve them faster and in a more cost efficient manner.

III. PRACTICE PARAMETERS/GUIDELINES
The development and implementation of medical practice parameters, coupled with other medical liability reforms, is an essential element of AHA's health reform vision. Medical practice parameters are guidelines for patient treatment, developed to provide physicians with a framework for clinical decision-making. Practice parameters are viewed as a vehicle to ensure the quality of care provided and to reduce the cost of health care. AHA believes that physicians who can demonstrate compliance with a practice parameter or guideline should be able to present that compliance as an affirmative defense in a lawsuit.

Adoption of medical practice parameters, along with other liability system reforms, would help to discourage or eliminate spending on unnecessary services by reducing the practice of defensive medicine. Currently, patients are subjected to unnecessary tests and treatment as physicians seek to protect themselves against potential liability. With practice parameters to follow, physicians would be less likely to furnish services beyond the appropriate treatment called for in the guidelines. Practice parameters would also enhance access to high risk specialty services, making physicians less inclined to stop providing these services. Access to even primary care suffers today, with 1 out of 8 obstetricians refusing to deliver babies due to the high liability risk. Practice parameters would help address such problems, which are having an adverse effect on the traditional physician/patient relationship.

AHA notes that the federal Agency for Health Care Policy and Research (AHCPR) currently is developing practice parameters for a number of medical specialty areas, at the direction of Congress. AHA supports AHCPR's efforts as an important element of medical liability and overall health care reform.

IV. UNIFORM STANDARDS FOR MEDICAL LIABILITY
Concern over the rapidly increasing costs and problems of access to health care for many Americans strongly suggests the need to implement long-discussed tort reforms. AHA, along with members of the National Medical Liability Reform Coalition (NMLRC), has endorsed some specific medical liability principles as essential to reforming the medical liability system, as well as the health care delivery system. Materials developed by the NMLRC are attached. These principles include the following specific reforms: 1) caps on noneconomic damages; 2) elimination of the collateral source rule; 3) regulation of attorneys' fees; 4) periodic payments; and 5) elimination of joint and several liability.

In order to incorporate these principles into a federal health reform system, federal preemption of existing state laws is necessary. Many states have been unsuccessful in adopting medical liability reforms, while some others have implemented significant reforms. Federal law should preempt corresponding provisions of state law, unless the state law is considered more effective. This preemption would allow states the ability to implement standards designed to meet their own needs, while providing some level of reform in all medical liability actions. AHA supports a uniform federal standard for medical liability that would preempt state laws, but only to the extent that the laws are less stringent than the federal standard.

CAPS ON NONECONOMIC DAMAGES. Trends in trial verdicts across the country establish that noneconomic damages in medical malpractice cases are higher than in other tort verdicts. Moreover, noneconomic damages have consistently proven to be the highest component of a malpractice verdict and, in many cases, disproportionate to any compensatory damage award. Noneconomic damages--which traditionally include pain and suffering, disability and disfigurement, loss of consortium, mental anguish, emotional distress, psychic injuries and loss of society--have the biggest adverse financial impact on health care providers.
AHA supports caps which limit the dollar amount of noneconomic damages a plaintiff may be awarded. Such limits will ensure that plaintiffs are justly compensated for damages incurred, yet prevent "runaway" awards for noneconomic damages, allowing health care dollars to be better spent on patient care.

ELIMINATION OF THE COLLATERAL SOURCE RULE. The collateral source rule prohibits defendants from introducing evidence that expenses incurred by an injured plaintiff have already been or will be paid by someone other than the defendant. This prevents the court or jury from taking into account the fact that part of the plaintiff's expenses are already covered by another source such as health insurance, disability compensation, and income protection insurance when determining the amount of damages to be awarded. The effect of the rule is to award a double recovery for these payments from other sources. Elimination of the collateral source rule would have a considerable impact on malpractice premiums, reducing them by as much as 15 percent.

AHA supports a direct offset of all collateral sources received by the plaintiff. No evidence of collateral sources would be presented to the jury; the offset would occur after the award was determined. Certain collateral sources such as Social Security and life insurance benefits would be exempt. In addition, credit would be given for premiums or other payments that have been made by the plaintiff to obtain the collateral benefits.

REGULATION OF ATTORNEYS' FEES. Traditionally, attorneys have used the contingent fee and hourly rates as two forms of client payment arrangements. The contingent fee arrangement is typically used by attorneys in the malpractice setting. Under this fee structure, a successful plaintiff's attorney receives a percentage of the plaintiff's award. If the plaintiff is unsuccessful, the attorney receives no compensation. This fee arrangement is especially desirable for plaintiffs who do not have the financial resources to pay attorney costs billed on an ongoing basis. The amount of the contingency fee, therefore, normally reduces the amount of money available for care of the injured plaintiff.

The verdict or settlement in a malpractice case is usually dependent on the severity of the injury and not the amount of legal services rendered. Thus, there may be no more work involved in recovering a $3 million dollar verdict than a $300,000 verdict. Because the contingency fee reduces the money available to the plaintiff, it is important to establish a schedule for attorneys' fees which would ensure adequate compensation for the plaintiff, proper representation for medical liability claimants, and

reasonable attorneys' fees. Such a schedule would allow the plaintiff to receive a greater portion of the recovery amount.

PERIODIC PAYMENTS. Traditionally, judgments in medical malpractice cases have required lump sum payment of damages for the plaintiff's past and future losses. Periodic payments would allow compensation to be made in intervals rather than a lump sum, and would permit structured settlements geared to a plaintiff's needs to fully protect the plaintiff over the course of his or her life. In addition, because periodic payments can be funded through an annuity, future needs can be met at a considerably lower cost to the health care system. AHA supports requiring periodic payment of damages in medical malpractice cases.

JOINT AND SEVERAL LIABILITY. The rule of joint and several liability provides that each defendant could be jointly and severally liable, meaning that any defendant could be liable for the entire amount of the award regardless of proportionate culpability. Thus, the rule generally punishes a co-defendant who is fully insured or has substantial assets to satisfy the judgment--the so called "deep pocket" defendant. This theory makes settling by a minimally negligent defendant difficult or impossible when the co-defendant is either uninsured or underinsured. AHA supports abolition of the joint and several rule and believes eliminating the rule will significantly reduce liability costs for hospitals.

ADDITIONAL TORT REFORMS. In addition to the above referenced principles for uniform standards of medical liability, AHA supports a modified statute of limitation with a two year reasonable discovery rule and a four year statute of repose. This would include a special exception for minors which would allow up to four years for children under six to initiate a claim. Finally, AHA supports the concept of certifying expert witnesses for any claim filed either through the civil justice system or brought in an ADR proceeding. An expert witness must be accompanied by an affidavit from an individual qualified to be an expert asserting that the claim brought forward has merit. Affidavits of merit filed with complaints will help screen out frivolous lawsuits.

Effective tort reform should result in a more efficient and equitable distribution of medical liability dollars. Savings realized from these reforms could not only serve to reduce the overall costs associated with health care spending, but could also serve to redistribute the savings and begin delivering more cost effective, quality care.

ENTERPRISE LIABILITY

Enterprise liability is a concept that is receiving increasing attention as an element of health care reform. Early proposals for enterprise liability suggested transferring all liability in malpractice cases to hospitals and away from individual physicians. More recently, enterprise liability is being discussed as applicable to accountable health plans (AHP's) as the "enterprise." AHA is interested in gaining a better understanding of enterprise liability and how it would be applied to a network or AHP, as well as whether it would help meet the goals of medical liability reform.

As health care moves closer toward a system of integrated provider networks responsible for delivering a total package of care, a need may develop to consider an organizational liability concept. It is important to note, however, that enterprise liability could not be applied to our current delivery system. While enterprise liability is an idea that may complement the fundamental goals of health reform, a number of issues need to be resolved before it could be

implemented. Without a reformed delivery system, imposing enterprise liability would mean that AHP's or networks (or hospitals, under early proposals) would bear a much greater liability exposure while having little control over the providers for which they are assuming the risk.

Generally, whatever or whomever has exposure for liability needs to be in a position to control the providers and others furnishing care, in order to be able to assess and reduce risk. New relationships between providers within the network, and between providers and the network, therefore will need to be established before enterprise liability could apply. A clear determination of who (or what entity) is ultimately responsible for the care of the patient will be necessary. A related issue is the treatment of providers who contract with an AHP or network to provide services, but are not under the direct control of the AHP or network. How the "enterprise" could accurately assess and control risk in such a setting is unclear.

Once a network is defined and established, systems must be put in place to measure and evaluate performance. These systems are essential to enable an assessment of liability risk. Outcomes research and practice guidelines will be helpful in developing performance standards. In addition, networks must have systems for ensuring compliance with established performance standards, such as quality assurance and peer review systems. Only after an AHP or network is operating with such mechanisms in place could it possibly insure against medical liability.

Finally, and most importantly, enterprise liability cannot be effective in addressing the medical liability issue unless it is accompanied by mandatory federal tort reforms for medical malpractice claims. Indeed, enterprise liability without tort reform would create a large, institutional "deep pocket" for litigants, thereby exacerbating the problem and resulting in a greater willingness for plaintiffs to sue. Such tort reforms must be mandated at the federal level, as the majority of states have been unable to enact effective state legislation.

Enterprise liability with mandated tort reforms may be a useful element of medical liability reform, if applied to a new health care system, combined with other measures, and accompanied by a clear definition of networks or accountable health plans. In addition, current laws governing provider relationships may need to be modified if enterprise liability is to apply.

CONCLUSION

AHA strongly supports reform and restructuring of the health care delivery system to address the problems of limited access, high cost, and fragmented delivery of care. Medical liability reform plays an important role in health care reform because of the high cost, inefficiency, and inequity of our current compensation system. Billions of dollars in health care savings and enhanced access to care can be achieved by changing the liability laws to discourage or eliminate spending on unnecessary services and reduce the fear of providing high risk services.

Like many other complex issues of health reform, medical liability demands a federal solution to ensure that all Americans have access to a system that compensates patients adequately and equitably. A package consisting of federal tort reforms for malpractice claims, implementation of patient safety mechanisms, exploration of alternative dispute resolution systems, and the development of effective practice guidelines would effectively address the medical liability issue.

National
Medical Liability
Reform Coalition

MEDICAL LIABILITY: PRINCIPLES FOR REFORM

The undersigned organizations, including members of the National Medical Liability Reform Coalition (NMLRC), believe that as the national debate on health care reform issues proceeds, we must address problems caused by the high cost, inefficiency and inequity of our medical liability compensation system. The undersigned organizations share an increasing concern that the medical liability compensation system is failing to meet its own goals of compensating injured patients and effectively deterring bad health care practices.

The Problem

People injured by medical malpractice or defective medical products are entitled to fair and prompt compensation for their injuries. All parties should have the right to a fair and cost-effective dispute resolution process. However, we believe that in resolving medical and product liability claims, the civil justice system currently:

* Costs far too much and works much too slowly;
* Fails to provide access to the legal system or fair compensation to most patients injured by medical malpractice, while providing exorbitant awards to others;
* Is unable to promptly or cost-effectively identify unfounded claims;
* Fails to adequately promote quality health care or protect patients from avoidable injuries;
* Adds billions of dollars annually to the national health care bill in medical liability premium costs and by encouraging doctors and other health care providers to practice "defensive medicine" as a hedge against potential lawsuits;
* Threatens access to health care, especially higher risk services, such as obstetrics and emergency room care;
* Adds unnecessarily to the cost of pharmaceuticals and medical devices; and
* Inhibits health care product research and development, reducing the availability of potentially valuable new drugs and medical devices.

The impact of our medical liability system has been studied extensively by the Department of Health and Human Services, the Justice Department, the General Accounting Office, the National Academy of Sciences, and the Harvard School of Public Health, among others. The studies reveal widespread agreement that this inefficient system adds to the serious problem

we now face of making health care services available to all Americans and effectively managing health care costs.

The federal government, as the single largest purchaser of health care services, has a strong interest in promoting the availability and quality of medical care and managing its cost. As part of that concern, it should lead in effectively addressing medical liability concerns.

Principles of Medical Liability Reform

The undersigned groups support the following principles prepared by the NMLRC, derived from the 1987 Department of Health and Human Services Report of the Task Force on Medical Liability and Malpractice. These principles should guide the restructuring of the current medical liability system.

I. AVAILABILITY OF HEALTH CARE: A compensation system for medical injury should promote the basic goal of providing access to necessary health care services to all.

II. QUALITY OF HEALTH CARE: A compensation system for medical injury should deter substandard or unethical practices and encourage improvements in the safety and quality of medical care.

III. PATIENT-PROFESSIONAL RELATIONSHIP: A compensation system for medical injury should enhance, not impair, a cooperative relationship between patients and health care providers, based on mutual respect and effective communication.

IV. FAIR COMPENSATION: A compensation system for medical injury should compensate patients injured by malpractice adequately and equitably.

V. PROMPT RESOLUTION: A compensation system for medical injury should resolve claims promptly.

VI. INNOVATION: A compensation system for medical injury should encourage innovation in diagnosis and treatment, leading to better care.

VII. PREDICTABILITY: A compensation system for medical injury should provide predictable outcomes with respect to findings of liability and amount of awards.

VIII. COST EFFECTIVENESS: A compensation system for medical injury should operate efficiently and economically.

We urge the Congress and the President to work to enact meaningful medical liability reform legislation consistent with the principles enumerated above.

February 1993

SUPPORTERS OF NATIONAL MEDICAL LIABILITY REFORM

Academy of Model Aeronautics
Alaska State Medical Association
American Academy of Family Physicians
American Academy of Neurology
American Academy of Orthopaedic Surgeons
American Academy of Pediatrics
American Association of Blood Banks
American Association of Neurological Surgeons
American Association of Nurse Anesthetists
American Association of Public Health Physicians
American Chiropractic Association
American College of Cardiology
American College of Nurse - Midwives
American College of Obstetricians & Gynecologists
American College of Osteopathic Surgeons
American College of Pain Medicine
American College of Physicians
American College of Radiology
American College of Rheumatology
American College of Surgeons
American Dental Association
American Fertility Society
American Group Practice Association
American Healthcare Systems
American Hospital Association
American Legislative Exchange Council
American Managed Care & Review Association
American Medical Association
American Nurses Association
American Osteopathic Association
American Optometric Association
American Podiatric Medical Association
American Protestant Health Association
American Psychiatric Association
American Society for Healthcare Risk Management
American Society for Surgery of the Hand
American Society of Internal Medicine
American Thoracic Society
American Tort Reform Association
Association of American Medical Colleges
Association of Black Cardiologists
Association of Private Pension & Welfare Plans
Auburn Foundry, Inc.
Auto Vehicle Parts Company
Belden Brick Company
Blood Center of Southeastern Wisconsin
Borg Adjustable Joint Hanger Company
Californians Allied for Patient Protection
Catholic Health Association
CBI Industries, Inc.
Coastal Corporation
Coastal Lumber Company
College of American Pathologists
Congress of Neurological Surgeons
Cooper Industries
Council of Community Blood Centers
Court Security Systems, Inc.
Damon Raike & Co.
Daughters of Charity National Health System
DC Metropolitan Area Chapter of the American College of Radiology
Dover Corporation
Dow Chemical Company
Dukane Corporation
Erdman, Anthony Associates
Federation of American Health Systems
Florida Radiological Society
Fluor Corporation
Gehris, Herey & Associates
Great American Insurance Companies

(continued on page 2)

SUPPORTERS OF NATIONAL MEDICAL LIABILITY REFORM *Page 2*

Great Plains Ventures, Inc.
Group Health Association of America
Grubbs and Company, Inc.
Hanover Insurance Companies
Harris, Birkhill, Wang, Songe & Assoc., P.C.
Hoffmann-LaRoche, Inc.
Hospital Corporation of America
Health Insurance Association of America
Humana, Inc.
ICI Americas, Inc.
Independent Gas Company
Iowa Radiological Society
Kaiser Permanente
Kansas Radiological Society
King, Hall & Associates
Lafarge Corporation
Louisiana Coalition for Maternal and Infant Health
Lovell Safety Management Company
Loyola Institute for Health Law
Lukens Inc.
March of Dimes
Massachusetts Financial Services Company
Medical Society of the State of New York
Metropolitan Life Insurance Company
Mississippi Valley Regional Blood Center
MMI Companies, Inc.
National Association of Childrens Hospitals
National Association of Manufacturers
National Association of Pediatric Nurse Associates and Practitioners
National Council of Community Hospitals
National Medical Association
National Rural Health Association
National Small Business United
Noble Lowndes
North Dakota Medical Association
Ohio State Radiological Society
Oklahoma State Radiological Society
Oregon Medical Association
PCS, Inc.
Perkin-Elmer Corporation
Permanent Magnet Co., Inc.
Pharmaceutical Manufacturers Association
Physician Insurers Association of America
Premark International, Inc.
The Psych Associates
Radiology Society of Louisiana
Radiology Society of New Jersey
Robbins & Myers, Inc.
Robert Betz Associates, Inc.
Rogers Mechanical Company
Seagull Operating Company, Ltd.
SHW Inc.
Society of Gastrointestinal Radiologists
Society of Radiologists in Ultrasound
Society of Uroradiology
Specialty Coatings Group, Inc.
Standard Products Company
Taylor-Winfield Corporation
Texas Civil Justice League
Texas Medical Association
Thermal Ceramics
Tort Reform Association of Kentucky
Universal Tool & Stamping Co., Inc.
U.S. Chamber of Commerce
U.S. Healthcare, Inc.
The Virginia Insurance Reciprocal
Voluntary Hospitals of America
Washington Business Group on Health
Western Manufacturing Corporation
W.H. Brady Company

National
Medical Liability
Reform Coalition

February 1993

NATIONAL MEDICAL LIABILITY REFORM COALITION

Medical Liability Reform
Essential Provisions to be Included in
Federal Health System Reform Bills

It is essential that comprehensive health system reform include effective medical liability reform, if cost containment and health care access objectives are to be achieved. The medical liability component of a comprehensive health system reform proposal should contain the following provisions:

1. Patient Safety Reform

   — States would be required to establish mandatory patient safety programs

   — Licensed professionals must participate at least once every three years in programs tailored to their particular profession and specialty

   — Each liability insurer must provide or endorse risk management programs to its insureds

   — Each health care facility or institution is required to have in effect a risk management program

2. Alternative Dispute Resolution (ADR)

   — Federal support of state demonstration projects to evaluate the merits of ADR proposals designed to divert claims from the civil justice system and resolve them faster and more cost-effectively

   — Federal government to evaluate after 5 years

3. Practice Parameters/Guidelines

-- Federal support for the evaluation of present and future state demonstration projects to examine the potential for practice parameters/guidelines to improve patient safety and discourage defensive medicine

-- Federal government to prepare a report after 5 years

4. Uniform Standards for Medical Liability Claims

A) Periodic payment of future damages over $100,000

B) $250,000 limit on non-economic damages

C) Mandatory offsets for collateral sources

-- Claimant gets credit for out of pocket expenses paid to acquire the collateral source

D) Plaintiff lawyer fees limited by sliding scale

E) Proportionate liability among all parties

-- Each defendant is liable for the percentage of damages that he or she caused

F) Statute of limitations

-- Two year "reasonable discovery" rule with 4 year statute of repose

-- Special exception to statute of limitations for minors, which would allow up to 4 years for children under 6 to initiate claims

G) Special obstetrics rule for drop-in patients

-- If a health professional has not previously treated a patient for pregnancy, burden of proof is "clear and convincing evidence"

H) Expert Affidavit

-- Any claim filed in court or an ADR proceeding must be accompanied by an affidavit from an individual qualified to be an expert witness asserting that the claim has merit

Federal Preemption of State Law

The above uniform standards of federal law preempt corresponding provisions of state law unless the latter are more effective. State law is preempted whether or not a state participates in ADR or practice parameters/guidelines demonstration projects.

Scope of Reform

The above reforms should apply to any claim arising from health care services offered by health care professionals or institutional providers in any state or territory.

All claims arising from the delivery of blood services should be included in this reform legislation; suppliers of blood services should be included in definition of health care providers.

Product liability claims should not be subject to the provisions of this medical professional liability reform legislation.

Reforms do not create a federal cause of action or otherwise alter federal court jurisdiction or state choice of law and venue.

SUPPORTING ORGANIZATIONS

American Academy of Family Physicians
American Academy of Orthopaedic Surgeons
American Academy of Pediatrics
American Association of Blood Banks
American Association of Nurse Anesthetists
American College of Cardiology
American College of Obstetricians & Gynecologists
American College of Physicians
American College of Radiology
American College of Surgeons
American Dental Association
American Fertility Society
American Group Practice Association
American Healthcare Systems
American Hospital Association
American Medical Association
American Osteopathic Association
American Podiatric Medical Association
American Thoracic Society
American Tort Reform Association
MMI Companies, Inc.
National Association of Manufacturers
National Association of Pediatric Nurse Associates & Practitioners
National Council of Community Hospitals
Physician Insurers Association of America

Chairman STARK. Mr. Smarr.

STATEMENT OF LAWRENCE E. SMARR, EXECUTIVE DIRECTOR, PHYSICIAN INSURERS ASSOCIATION OF AMERICA

Mr. SMARR. Mr. Chairman, members of the subcommittee, my name is Larry Smarr, and I am the executive director of the Physician Insurers Association of America. On behalf of the 190,000 physicians and surgeons insured by our member companies, I am grateful for your invitation to testify today.

The PIAA is an industry organization formed by the physician companies to address the problems associated with medical malpractice. All of our companies are doctor owned or run and are in business primarily to provide a stable and effective market for medical malpractice insurance. They were formed starting in the mid-1970s when virtually all the commercial carriers which had historically provided this line of business either withdrew from the market or raised their prices to intolerable levels.

Doctors facing this crisis didn't turn to the government at all for help, they formed their own physicians companies with their own money and provided their own market. In 1975, we had a problem with the availability of the product. In 1993, we continue to have a problem with the high cost of malpractice insurance caused by litigation.

This time, we don't have the power to solve the problem on our own and we look to the Federal Government for assistance.

I am here to tell you three things. The first is that our current system is ineffective and inefficient. The second is to tell you how we propose you deal with this. And third, I would like to address the topic of enterprise liability.

There are five major reasons why our system is inefficient and the first is obviously the high cost of awards. Our data show that only 16 percent of all paid claims have a value in excess of $200,000. However, they account for 66 percent of the total indemnity dollar paid.

There are a few very large claims that skew the system. There are too many meritless claims. Only one in three medical malpractice claims winds up in an indemnity payment. Of the 8 percent of these claims that get to verdict, our companies win 80 percent in favor of the defendant. The claims take too long to resolve. They close on average 6 to 7 years after they happen. And the settlement process is often a lottery where payments are not representative of the injuries incurred.

There is faulty resource allocation of monies we raise. Too little of the vast amount of money collected actually goes to the deserving injured parties. Our studies show that over 43 percent of all money goes to attorneys, both plaintiff and defense.

We also feel that increased loss prevention efforts are necessary. We strongly endorse increased State efforts at improving patient safety to enhance licensing and credentialing procedures and believe that provider education and loss prevention efforts do have a significant role in modifying behavior and reducing bad outcomes. Second, we feel that tort reforms are necessary to address these issues.

In order to control this spiraling cost of the malpractice insurance tort reforms will be required. This has been demonstrated in California by MICRA as mentioned by previous speakers. Because of these reforms, insurance premiums in California actually have been reduced by 60 percent during the period 1976 through 1991. At the same time, premiums across the Nation have skyrocketed.

The third item I would like to address is enterprise liability which we see as cost shifting and not saving. We understand that the President may include enterprise liability in the health care reform proposal under which physicians and presumably all other health care providers will be relieved of malpractice liability.

Newly formed entities called accountable health plans will be the recipients of malpractice actions and plaintiffs will no longer be able to sue their doctor but will have to sue the faceless AHP. There are problems caused by this new mode, because the AHP will be a very large target, a good example of a deep pocket for the trial bar.

Awards can be expected to be larger, not smaller, because of the larger limits of coverage available. Plaintiffs and their attorneys will now be suing a faceless business organization and the number of suits can be expected to increase. It is much easier to bring a meritless claim against a big business organization than against your family doctor and right now we know that two-thirds of all claims that are filed are meritless.

Physicians will be eviscerated of their individual of their individual rights and responsibilities to defend their actions against negligence. AHPs undoubtedly will be much more inclined to do make economic settlements of the meritless claims which is a complete reversal of the new recognized stance of the physician-owned carriers.

Under the scenario, the proposed plan will place the AHP and physician at odds as the quality of care rendered will be questioned by the AHP when actions are filed and instead of the courts determining liability the LP will now perform this function with regard to the practitioner.

In conclusion, the PIAA believes that meaningful medical malpractice liability reform must be a key element in any overall health care reform package. This reform should be one that has worked in practice over a significant period of time rather than some untested theoretical concept like enterprise liability.

The Congress should seek, wherever possible, to include in it elements that have been tested and proven to have been workable and effective in the area of the medical malpractice reform.

The California provisions—MICRA—have been in existence for 18 years and have worked to reduce costs. This is neither the time nor the program to attempt to radical social experiment like enterprise liability. The stakes are too high and the payback is not evident.

Thank you. I will be glad to answer any questions you may have.

[The prepared statement follows:]

TESTIMONY OF LAWRENCE E. SMARR
EXECUTIVE DIRECTOR
PHYSICIAN INSURERS ASSOCIATION OF AMERICA

INTRODUCTION

Mr. Chairman, Members of the Subcommittee, my name is Lawrence E. Smarr. I am the Executive Director of the Physician Insurers Association of America, which is commonly known as the PIAA. On behalf of the 190,000 physicians and surgeons insured by our member companies the United States, I am grateful for your invitation to testify today and welcome the opportunity to share with the Subcommittee our views on medical malpractice reform.

The PIAA is an industry organization comprised of insurance companies which were formed since the mid 1970's by physicians to address the problems associated with medical malpractice. All of our companies are doctor owned and/or run, and are in business primarily to provide a stable and effective market for medical malpractice insurance, and at the same time keep premiums as low as prudently dictated by operating on a break-even basis. Our companies were formed starting in the mid 1970's when virtually all of the commercial carriers which had historically provided this coverage either withdrew from the market or increased prices to intolerable levels. Doctors facing this crisis didn't turn to the government for help, they formed their own companies, with their own money, and solved their problem. We are please to report that our companies, owned and operated by the doctors they insure, have been most successful at what they do. Our 44 member companies, located across the nation and in virtually every state, serve as examples of American enterprise and business ingenuity. In 1975 we had a problem with the availability of malpractice insurance, and we solved that. In 1993 we still have a problem with the continuing high costs of malpractice litigation. This time, we don't have the power to solve this problem. Only the government can do it. While the leading symptoms may differ, the cause of this disease continues to be the same - our tort system for resolving malpractice claims is incredibly inefficient, costing far to much to operate and awarding far to little to those who rightly deserve to be compensated.

THE PRESENT SYSTEM IS INEFFICIENT

There are five major reasons why the existing tort system is inefficient and must be reformed:

1. **THE HIGH COST OF AWARDS** - The major cost component of medical malpractice insurance is the amount paid to indemnify injured parties. We strongly support the prompt and just indemnification of injured parties. However, we have seen our tort system award ever increasing amounts for non-economic damages, which play a great role in driving up insurance and health care costs. Our data shows that only 16 percent of all paid claims have a value of $200,000 or more, but they account for 66% of all indemnity dollars paid. Contrary to the opinion of some, there are many small claim payments. Paid claims under $50,000 represent 54 % of claims, but only 7.6% of total indemnity. A cap on non-economic damages is required to control these costs, and will clearly not deny access to plaintiffs having claims with potential small awards.

2. **TOO MANY MERITLESS CLAIMS** - Only one in three claims or suits results in an indemnity payment to the plaintiff. Those which close without payment cost over $19,000 to defend. Of the eight percent of all suits which actually go all the way to verdict, over 80% are decided in favor of the defendant. From this, one should draw the conclusion that a very inefficient element of this system is the plaintiffs' bar. They don't win much, but when they do, they win big! The average of the malpractice payments currently reported to the PIAA Data Sharing Project is just under $200,000. This has doubled over the past five years, while the nature of the injuries to the patient have remained the same.

3. **CLAIMS TAKE TOO LONG TO RESOLVE** - Malpractice claims are reported to insurers on average 22 months after they are alleged to have occurred, and they close on average six to seven years from the date of incidence. The settlement process is often a

lottery where payments are not representative of the injuries incurred. We can thank our tort system for this.

4. **FAULTY RESOURCE ALLOCATION** - Too little of the vast amount of money collected actually goes to deserving injured parties. Over 43% of all monies available from premiums and investment income goes to attorneys, both plaintiff and defense. Defense attorneys hired by insurance companies always get paid, and when they prevail, the contingency fees paid to plaintiff attorneys exceed 1/3 of the settlement or award. The purpose of the system is to make the patient whole, so why are we giving so much away to the lawyers?

5. **INCREASED LOSS PREVENTION EFFORTS NEEDED** - The experience of the PIAA companies over the years shows that, while many doctors are claimed against, very few have claims with merit. However, there is indeed malpractice, and our state systems of licensure must be improved to identify and remove substandard practitioners before acts of negligence occur. We strongly endorse increased state efforts at improving patient safety through enhanced licensing and credentialling procedures, and believe that provider education and loss prevention efforts do have a significant role in modifying behavior and reducing bad outcomes.

NECESSARY TORT REFORMS

In order to control the spiraling costs of malpractice insurance, tort reforms will be required. This has been demonstrated in California, where the Medical Injury Compensation Reform Act of 1975 has had significant and measurable effects on the medical malpractice insurance market. In 1975 insurance rates in California were among the highest in the country, and are now among the lowest. The member companies of the PIAA strongly advocate national tort reform encompassing the primary components of MICRA. These are:

1. $250,000 limit on non-economic damages

2. Periodic payment of future damages over $100,000

3. Mandatory offsets for collateral sources, where the claimant is reimbursed more than once for out of pocket medical and other expenses.

4. Plaintiff lawyer fees limited by a sliding scale.

Because of these reforms, medical liability premiums have actually been reduced by 60% in California during the period 1976 - 1991. At the same time, premiums in the rest of the nation have skyrocketed. In 1992, insurance coverage for an OB/GYN was $39,300 in California, while comparable coverage in New York was $85,800, Florida $130,600 and in Michigan it was $141,900. Clearly, MICRA has been effective. It exists, it is proven and leaves little to the imagination in its implementation. Experience has shown that such reforms have not served to deny access to the legal system, and more of the resources available to pay claims actually go to those who deserve them - the injured patients - not their attorneys.

ENTERPRISE LIABILITY - COST SHIFTING, NOT COST REDUCTION

While nothing has been published or officially released yet, it is our understanding from conversations with the Administration's Health Care Task Force that the principal component of malpractice reform which the President will include in his Health Care Reform Proposal will be Enterprise Liability, under which physicians will be relieved of malpractice liability. Newly formed entities understood to be part of the overall health care plan called Accountable Health Plans (AHPs) will be the recipients of all malpractice actions caused by individual provider care. Providers will no longer be defendants in name, but are expected to serve in the role of witness. This will be very similar to a concept called channelling, which

has been adopted on a limited basis is a few areas of the country in controlled hospital environments.

Plaintiffs will no longer be able to sue their doctor, but will have to sue the faceless AHP. Hospitals should continue to be the focal points of care under this managed setting, and certainly can be expected to be the bulls eye of the institutional target. Sixty-five percent of all medical malpractice claims occur in a hospital.. Administrative savings may be exacted because cases which arise from treatment provided by multiple individuals will be reduced to one claim against the AHP, thus only requiring one defense.

The Administration admits that the additional costs in administering the new Enterprise Liability modality may equal or even exceed the savings expected from the new "big business" defendant.

PROBLEMS CAUSED BY ENTERPRISE LIABILITY

Under the current tort system, which would not be altered or replaced by Enterprise Liability itself, only one of every three malpractice claims brought by plaintiffs and their attorneys result in an indemnity payment. The other two are either won by the defendant, dropped by the plaintiff, or dismissed by the court. However, all of these claims are very costly to defend ($19,000 each). Malpractice claims are reported to insurers approximately two years after the alleged incident has occurred, and are concluded on average 6-8 years after the incident, with all of this delay being due to the tort resolution system.

Enterprise Liability does nothing to address these issues, and in fact, introduces these additional concerns:

1) The AHP is a large target, and the best example of the deep pocket provided by the trial bar to date. Awards can be expected to be larger, not smaller, because of the much larger limits of coverage available. Bigger pot, bigger servings.

2) Plaintiffs and their attorneys will now be suing a faceless business organization, and the number of suits can be expected to increase. It is much easier to bring a meritless claim against big business than against your family doctor. Fully two thirds of all claims brought now are meritless.

3) Physicians will be eviscerated of their individual rights and responsibilities to defend their actions against allegations of negligence. AHPs will undoubtedly be much more inclined to make economic settlements of meritless claims, which is a complete reversal of the now recognized stance of the physician owned carriers.

5) While providers will no longer be required to purchase malpractice insurance, they will undoubtedly still have to share in their fair burden of the insurance costs. Administration officials have opined that this may be done through reimbursement mechanisms.

6) At present, a practitioner's insurance policy follows him wherever he practices. In the future, practice at multiple AHPs will introduce coverage coordination problems, and if "in-kind" payment is made by the physician through reduced reimbursement for services, this will require a complicated accounting system. How does a physician reflect this on his taxes?

7) Historically, relationships between medical staffs and institutions have not been harmonious. With the introduction of the AHP as the umbrella corporate body, it is likely that the physician/AHP relationship will be even poorer. The proposed plan will place the AHP and physicians at odds as the quality of care rendered will be questioned by the AHP each time an action is filed against the AHP. Instead of the courts determining liability, the AHP will now perform this function with regard to the practitioner. The court is a neutral

party in such actions, but the AHP cannot be so.

8) Because it bears the brunt of the liability exposure, the AHP will be inclined to try to control the malpractice risk by management technique. AHPs, which will not practice medicine, will try to exert more control over practitioners in an attempt to prevent claims from occurring. This may even cause a rise in defensive medicine practices where the AHP stands to benefit from the delivery of medical services. This will cause the AHP to want to perform those procedures with a higher profit margin and constrict the number of procedures which are not big money makers. Standards of care will be set by AHPs with the profit margin being one of several determinants.

11) While the Administration may feel that the doctor-patient relationship may be improved by the removal of the threat of suit, it may even become more strained because of the increased control and practice standards which will undoubtedly be placed on them by the corporate AHP.

12) When an action is brought against an AHP for the acts of a practitioner and the AHP and the practitioner differ in their views of the merits of the action, then they become legal adversaries. Practitioners will be forced to defend their rights, possibly the right to practice medicine, against the AHP.

13) Reporting of malpractice payments to the National Practitioner Data Bank will become a major issue. At present, physicians have considerable control over whether their claims are settled or not, and under Enterprise Liability, they will not. Since all claims will be made against the corporate AHP, payments will not be required to be reported under the current law. Unless direct liability is determined by individual practitioner, this reporting mechanism will not be viable as intended by the Congress.

14) Doctors will not be held liable under the law except for acts of gross negligence. In poorly run AHPs, this will permit those few substandard practitioners to become even more lax in their practices, because the threat of action directly against them will be removed. Physicians are now held accountable by societal standards which will be removed and replaced by corporate guidelines.

15) The large insurance carriers, which will be the only ones capable of providing coverage to the large corporate AHPs, will once again dominate the medical malpractice insurance marketplace. The specialty medical malpractice insurance carriers which now provide intense and meaningful loss prevention services will be replaced by the large commercial carriers which are in business to only make money. Physician education and loss prevention services have been most effective in reducing the increases in costs of malpractice coverage over the past twenty years. However, the effects of these services, claims not made, cannot be reflected on an income statement. The commercial carriers have still not recognized the long term benefits that these practices hold for physicians and their patients, and there will be no incentive for them to do so in the future.

At best, Enterprise liability will shift the burden of malpractice costs from individual providers to AHPs. The doctors will still have to defend their actions, however, they will loose the protections granted by the courts, which will be replaced by corporate standards and review procedures practiced by the AHPs. The potential for larger awards and settlements will be increased by the aggregation of the risk in the AHP.

CONCLUSION

The PIAA believes that meaningful medical malpractice liability reform must be a key element in any overall health care reform package. This reform should be one that has worked in practice over a significant period of time rather than some untested, theoretical concept, like Enterprise Liability, which until two months ago was little more than a gleam in the eyes of two professors. Everyone agrees that overall health care reform, if enacted as a broad program, will be one of the most significant legislative and programmatic endeavors ever undertaken in this country. The problems of its design, its implementation and its

acceptability by those who must run it as well as those who will benefit from it will be monumental. The Congress should seek, wherever possible, to include in it elements which have been tested and have proven to be workable and effective. In the area of medical malpractice reform, the California provisions - MICRA - have been in existence for 18 years and have worked to reduce costs, reduce indemnity and have generally improved the climate between providers and patients. In short, they work. In contrast, Enterprise Liability is an untested, unproven concept that has no history. This is neither the time nor the program to attempt a radical social experiment like Enterprise Liability. The stakes are too high.

Chairman STARK. I thank the panel.
Dr. Green, you are next.

STATEMENT OF RICHARD P. GREEN, M.D., MEMBER, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Dr. GREEN. Mr. Chairman and members of the subcommittee, I am Richard P. Green, a practicing obstetrician-gynecologist here in the District of Columbia. I am testifying on behalf of the American College of Obstetricians and Gynecologists, an organization representing more than 33,000 physicians providing women's health care.

I wish to thank Chairman Stark and the members of the subcommittee for your interest in giving me the opportunity to testify today about a problem that begs to be rectified—the adverse effects of the liability crisis on obstetric care.

I would also specifically like to thank Representative Nancy Johnson for her leadership in bringing liability reform to the forefront. Her bill from the last Congress included most of the reforms that I will be recommending to you today.

I think the best way to demonstrate the problems associated with the liability system is through my personal story. I was born and educated in the District of Columbia. I am a Howard University Medical School graduate and have practiced here since 1973. I treat both Medicaid and other indigent patients in my practice, as well as private pay and third-party insured patients.

I still practice obstetrics, even though I will pay more than $60,000 this year for my malpractice insurance premium. Comparatively speaking, my malpractice premium pales in comparison to colleagues of mine who practice in Michigan—their yearly premiums could be as high as $141,100.

I am here today because I am concerned about my ability to continue to serve my obstetric patients. Some of my colleagues have given up the practice of obstetrics and others have given up the practice of medicine all together.

A close personal friend of mine stopped practicing completely and went to work for the Food and Drug Administration.

Unless the Federal Government begins to address the problems related to malpractice, I am afraid that many other colleagues and I will be forced to make similar choices.

Let me briefly describe the problem and suggest what can be done to address effectively the current medical liability situation.

According to a 1992 survey of ACOG's membership, 12.3 percent of obstetrician-gynecologists nationally had quit obstetrics and almost 25 percent had decreased the amount of high-risk obstetric care they provided.

Almost 80 percent of my board-certified colleagues had at least one claim filed against them. In the State of New York, nearly 90 percent of the obstetrician-gynecologists have been sued with the average number of suits filed against these New York doctors being four. Clearly the liability crisis is not primarily due to the "bad doctor."

The major problem is neither mine nor even that of the obstetrician-gynecologists who have quit obstetrics because of the malpractice situation. The problem is for our patients who ultimately

suffer from the liability situation, those who have difficulty finding an obstetrician-gynecologist to treat their high risk pregnancies and those for whom obstetric care is unaffordable because of the liability premiums their obstetrician-gynecologists have to pay.

The bottom line is that pregnant women in many areas of the country are having difficulty obtaining prenatal care. This is certainly true here in the District of Columbia. While it has never been safer for a woman to have a baby, it has never been riskier for a doctor to deliver one.

I decided to become an obstetrician-gynecologist because of the thrill of my first delivery during medical school. It was the first time anyone had ever called me "Dr. Green." My instructor held my hands in his and helped me guide a new little boy from his mother's birth canal into the world. There are few experiences in life which can match the satisfaction and joy of this.

But lately, this joy has been diminished. The delivery suite has become a battleground with patients and physicians pulled apart by an adversarial tort system which is out of control. Obstetric care will become unaffordable and unavailable if we allow liability risks and insurance premiums to continue to drive out dedicated professionals. We cannot allow the situation to deteriorate further and jeopardize the health of women and their infants in this country.

To avoid this, uniform Federal minimum standards for tort awards need to be enacted as detailed in our written statement. While few States have adequate tort reforms, the District of Columbia, our Nation's Capital, is the only jurisdiction with none.

In closing, I urge Congress to seize the opportunity to pass meaningful tort reform—today's deplorable liability situation can no longer wait. It would be a disservice to those seeking health care if we enact health care reform without addressing this critical problem.

On behalf of the women seeking obstetric and gynecologic care in this country, I beg you to pass legislation that would allow them access to the care they want and so rightfully deserve.

I thank you, Mr. Chairman.

[The prepared statement and attachment follow:]

TESTIMONY OF RICHARD P. GREEN, MD, FACOG
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Mr. Chairman and Members of the Subcommittee, I am Richard P. Green, MD, a practicing obstetrician-gynecologist here in the District of Columbia. I am testifying on behalf of the American College of Obstetricians and Gynecologists (ACOG), an organization representing more than 33,000 physicians providing women's health care. I wish to thank Chairman Stark and the Members of the Subcommittee for your interest in this issue and giving me the opportunity today to testify before the Subcommittee about a problem that begs to be rectified -- the adverse effects of the liability crisis on obstetric care. I would also specifically like to thank Representative Nancy Johnson (R-CT) for her leadership in bringing the need for liability reform to the forefront. Her bill in the last Congress, HR 1004, included most of the reforms that I will be recommending to you today.

I think the best way to demonstrate the problems associated with the liability system is through my personal story. I was born in the District, educated here, graduated from Howard Medical School, and have been in private practice here since 1973. I treat both Medicaid and other indigent patients in my practice, as well as private pay and third party insured patients. I still practice obstetrics, even though I will pay more than $60,000 this year for my malpractice insurance premium. Comparatively speaking, my malpractice premium pales in comparison to colleagues of mine who practice in Michigan -- their yearly premiums can be as high as $141,100.

I am here today because I am concerned about my ability to continue to serve my obstetric patients. Some of my colleagues have given up the practice of obstetrics; others, the practice of medicine. A close personal friend stopped practice completely and went to work for the FDA. Unless the federal government begins to address the problems related to malpractice, I am afraid that many other colleagues and I will be forced to make similar choices. Let me briefly describe the problem and suggest what can be done to address effectively the current medical liability situation.

According to a 1992 survey of ACOG's membership, 12.3% of obstetrician-gynecologists nationally had quit obstetrics and almost one-quarter had decreased the amount of high-risk obstetric care they provide because of the risk of malpractice. The same survey showed that almost 80% of my board-certified colleagues had at least one claim filed against them. In the state of New York, nearly 90% of obstetrician-gynecologists have been sued, with the average number of suits filed against these New York doctors being four. Clearly, the liability crisis is not primarily due to the "bad doctor."

The major problem is neither mine nor even that of the obstetrician-gynecologists who have quit obstetrics because of malpractice anxieties. The problem is for our patients who ultimately suffer from the liability situation -- those who have difficulty finding an obstetrician-gynecologist to treat their high-risk pregnancies, and those for whom obstetric care is unaffordable because of the liability premiums their obstetrician-gynecologists have to pay. The bottom line is that pregnant women in many areas of the country are having difficulty obtaining prenatal care. This is certainly true in the District. While it has never been safer for a woman to have a baby, it has never been riskier for a doctor to deliver one.

I decided to become an obstetrician-gynecologist because of the thrill of my first delivery during medical school. It was the first time anyone had ever called me "Dr. Green." My instructor held my hands in his and helped me guide a new little boy from his mother's birth canal into the world. There are few experiences in life that can match the satisfaction and joy of this.

But lately this joy has been diminished. The delivery suite has become a battleground, with patients and physicians pulled apart by an adversarial tort system, which is out of control. Obstetric care will become unaffordable and unavailable if we allow liability risks and insurance premiums to continue to drive out dedicated professionals. We cannot allow the situation to deteriorate further and jeopardize the health of women and their infants in this country.

I would now like to take the opportunity to share with you a story about one of my colleagues who practices in West Virginia. She has testified twice before the U.S. Senate -- once in 1986 and, most recently, in 1991. The first time she testified, her liability premium had just increased to $13,241 which, at that time, was a 400% increase. She begged the Senate to take action before physicians like her were forced out of practice.

When she returned to testify in 1991, she had already given up the practice of obstetrics at age 35 because her malpractice insurance premium had risen to $40,000 in 1990. Because of the economic situation in West Virginia, she couldn't pass along her increased costs to her patients, so she had no other choice than to drop her obstetric practice. She said before the Senate she "could not have believed in 1986 that she would be back testifying without the passage of a single piece of federal legislation to address the problem" of the liability crisis. I certainly hope I don't have to follow in her footsteps. Therefore, I have a few suggestions that can remedy our ailing tort system.

As part of ACOG's health care reform proposal, U.S. MaternaCare, we propose uniform federal minimum standards for tort awards. (A synopsis of U.S. MaternaCare is attached to this testimony.) Specifically, we believe the following reforms should be applied in all state and federal medical malpractice actions, unless a state has more stringent provisions:

- Awards would be reduced by the amount of items paid for from another source, such as health or disability insurance.
- There would be mandatory periodic payment of all future damages exceeding $100,000.
- A claim must be filed within 2 years of the date by which the alleged injury should reasonably have been discovered, but in no event more than 4 years from the time of the alleged injury, In the case of alleged injury to children under 4 years of age, a claim could be brought until the child's eighth birthday.
- There would be a $250,000 ceiling on noneconomic damage awards.
- Limits would be placed on punitive damages, with 50% of punitive damage awards going to a state disciplinary fund.
- When a health care professional who provided delivery services but did not provide prenatal care is sued, the case must be proved by "clear and convincing evidence," rather than the usual requirement of "preponderance of evidence."
- There would be a schedule of percentage limitations for attorney contingency fees.

These provisions are similar to those advocated by the National Medical Liability Reform Coalition, a broad-based group formed for the purpose of promoting federal medical liability reform as a key element of health care reform. They are also similar to California's MICRA reforms, which have been shown to be effective.

ACOG believes the collateral source rule, which prohibits the defendant from introducing evidence that the plaintiff has received payment for losses from another source, should be eliminated and replaced with a mandatory offset against awards for compensation received from other sources. The collateral source rule allows plaintiffs double recoveries since they can recover from government or private insurance companies and also in tort. To the extent that injuries are compensated more than once, insurance costs for all are increased.

Periodic payments provide another way to reduce the costs of liability actions without preventing the plaintiff from receiving a fair recovery. If the tort award for future damages is paid out over time rather than all at once, both the plaintiff and defendant benefit. The plaintiff is assured that money will be there when it is needed and the defendant's payout is made more predictable.

In addition, shortening the statute of limitations is important to obstetrician-gynecologists, both for cases involving adults and minors. Some states' statutes of limitation for medical liability claims permit plaintiffs an extraordinary amount of time within which to bring suit, particularly in the case of minors. This "long tail" phenomenon presents major problems for insurers in establishing rates and reserves and for defendants in producing evidence and witnesses. These problems are often compounded by a liberal "discovery rule," which may toll the statute until an injury is discovered or reasonably should have been discovered. Our limits would allow a reasonable time for actions to be brought, while providing a point beyond which a suit cannot be brought. This is, in our view, fair to all parties.

In the case of minors, some states allow a suit to be brought beyond the age of maturity. For an alleged injury at birth, actions can be brought in such states after more than twenty years. Such cases are obviously difficult to defend. Even good memories fade after twenty

years, the whereabouts of all relevant parties may not be known, and medical practices may have changed dramatically.

A cap on noneconomic damages, such as pain and suffering, has been an element in effective tort reform at the state level. This type of cap does not limit in any way recovery for economic losses, such as medical care expenses, rehabilitation, or lost income. However, it does limit what could otherwise be unlimited recoveries since noneconomic losses are difficult to quantify, as well as for which to insure. A cap on noneconomic damages is a reasonable approach since the plaintiff still receives full compensation for economic damages. ACOG believes $250,000 is a reasonable cap on noneconomic damages.

Reform of punitive damage is also needed. Limits should be placed on these damages, with 50% of punitive damage awards going to a state disciplinary fund. ACOG also supports a change in burden-of-proof law to allow use of "clear and convincing evidence" in a case where a health care professional who provided delivery services but not prenatal care is sued, rather than the current requirement of "preponderance of evidence."

There is an increased risk of an adverse outcome when a woman has not received prenatal care. Adjusting the burden of proof recognizes the increased difficulties the health care professional faces in these circumstances, while still allowing the patient who thinks she was treated negligently recourse.

The current system for compensating injured parties is time-consuming, with average delays of almost five years in ob/gyn cases before payment is made. It is also inefficient, with as little as 28% of the malpractice premium dollar going directly to the injured parties. To develop and test such a system, we support the establishment of a grant program to provide funds to states to encourage the development, implementation and evaluation of innovative systems for compensating individuals who are injured in the course of receiving health care services. These grants could be used to set up any one of five types of alternative dispute resolution (ADR) programs.

In closing, I urge Congress to seize opportunity and pass meaningful tort reform -- today's deplorable liability situation can no longer wait. It would be a disservice to those seeking health care if we enact health care reform without addressing this critical problem. By passing legislation, you can change stories like mine. On behalf of the women seeking obstetric and gynecologic care in this country, I beg you to pass legislation that will allow them access to the care they want and deserve.

U.S. MATERNACARE

A Synopsis of the American College of Obstetricians and Gynecologists' Proposal for Universal Access to Maternity Care

Millions of pregnant women are caught in the gaps in the current health care system, leaving their health status in a vulnerable position. It is estimated that of the 37 million Americans under the age of 65 who are uninsured, 9 million are women of childbearing age. The American College of Obstetricians and Gynecologists' (ACOG) proposal is designed to assure that all women have access to a full range of maternity care services, including family planning services and infant care for one year. Access to our health care system is important to all people, but if a starting point must be determined, maternity care should be that first step. Pregnant women who lack health insurance are less likely to obtain adequate prenatal care and are more likely to face a poor pregnancy outcome than are women with health insurance. Effective prenatal care also reduces maternal and infant mortality and can reduce the rate of low-birthweight babies born in this country.

Employer-Provided Insurance

Our proposal builds upon the strengths of the existing multiple financing and delivery system through an employer mandate. Employers would be required to offer maternity care benefits to employees who work more than 17 1/2 hours per week and their dependents. All plans would cover a nationally mandated basic benefits package that included maternity care. Smaller employers would have the choice of providing insurance or paying a percent of payroll to the federal government to cover the government's cost of providing such insurance to their employees through a government program. No co-payments, deductibles or other out-of-pocket charges for any of the services in the basic benefits package may be charged to the insured.

Health insurers would be required to:

- offer the maternity care package to all employers,
- use community ratings to determine the price of maternity care coverage,
- continue coverage throughout pregnancy, until the end of the 60 day period after delivery,
- sell policies without preexisting condition exclusions, and
- retain businesses without threat of cancellation of health insurance policy, except for specific reasons such as nonpayment of premiums or fraud.

Government Program

Any woman who does not have employer-provided maternity care coverage will be eligible for the government-sponsored program, regardless of her residency or citizenship status. For application, a woman would be required to give only minimal demographic and documentation data regarding her pregnancy and her lack of health insurance. Coverage for pregnancy-related care would be immediate upon confirmation of pregnancy and would continue for 60 days after delivery; newborns would be covered from birth until the end of the month of their first birthday.

Basic Benefits Package

All coverage, whether through private insurance or the public program, will include the following benefits based upon the health status of the woman and fetus: pregnancy diagnosis, abortion services, prenatal care, nutritional counseling, substance abuse counseling and treatment, prescription drugs, labor and delivery in a facility appropriate for the anticipated obstetric and neonatal risk, postpartum evaluation and services, social and other support services as needed (such as case management, home visiting and transportation), and health services for the infant for at least one year. In addition, all women would be eligible for family planning services, including sterilization and a pre-pregnancy related health evaluation, which would be limited to one such visit per year.

Quality Assurance

Each hospital, birth center or other facility would be required to operate an internal quality assurance program meeting federal standards set by the Secretary of Health and Human Services (HHS). Additionally, the facility will be required to contract with an entity certified by HHS to review periodically the care provided in the facility. This review would also examine medical occurrences that might indicate deficiencies in ambulatory care. State medical boards would be required to enter into agreements with state and local professional societies to provide review of unsafe practices and other such conduct by health care professionals. Physicians and other health care professionals would be required to assure that the care provided meets minimum standards by maintaining current licensure or certification.

Cost Containment

Coordinated delivery of obstetric services, accomplished by regionalization, would avoid duplication of costly facilities and equipment within the same geographic area. Rates for the program would be negotiated at the state level by relevant providers and all insurers as a group, and would be fair and adequate. Any reimbursement differential based on the patient's risk or the complexity of services would be determined by state negotiation. Balance billing would be permitted, only if the family income was in excess of 200% of the federal poverty guideline, the case was not a medical emergency, or if there was a limited choice of providers. Administrative costs would be reduced through the use of a single, universal claim form by both private insurers and public programs, with emphasis on electronic billing. There would also be physician education on the cost implications of specific practice and prescribing patterns. Health care professionals would automatically receive reimbursement for services provided consistent with applicable practice guidelines.

Malpractice and Tort Reform

Reduction of medical malpractice insurance premiums would be achieved through tort reform. The following tort reforms would apply to all medical malpractice cases: mandatory periodic payment of all future damages exceeding $100,000; a $250,000 ceiling on noneconomic damage awards; claims must be filed within 2 years from the date the alleged injury should reasonably have been discovered, but in no event more than 4 years from the date of the alleged injury (injuries to children under age 4 could be brought until the child's 8th birthday); punitive damages would be limited, with 50% of any amount awarded going to a state disciplinary fund; attorney contingency fees would be limited according to a schedule; awards would be reduced by the amount of items paid for from another source, such as health or disability insurance, and; "clear and convincing" evidence must be established when a physician is sued who provided delivery services but did not provide prenatal care, unless it was a group practice where there was an agreement to cover for another physician. Grants would be available to states to encourage the development, implementation and evaluation of innovative systems for compensating individuals who are injured in the course of receiving health care services. These grants could be used to set up any one of five types of alternative dispute resolution programs.

Chairman STARK. I want to thank the witnesses. A comment, first: In your testimony, I think you indicated that California's malpractice reform had helped to control the State reform costs. The evidence was quite to the contrary. It may have held down the premium, but we still have the second highest per capita cost and as stiff a growth rate as any State.

So there is precious little evidence that the malpractice reforms in California have done anything. While they may have lowered the premiums, the effects certainly didn't pass through to the benefit of the beneficiaries or to your patients.

I will address that comment to Drs. Green and Corlin, but now it is conceivable that this exercise is worth doing just to make Dr. Green's practice more friendly to physicians and to see that we have competent physicians practicing.

My question, again, to both Drs. Corlin and Green, in a personal sense, how would you change—let's assume for a minute that we just some ways forbid malpractice liability to exist, and say there would be some jury of your peers who would decide when you did something wrong. We take the complete worry off your shoulders.

How would you change the way you practice medicine? Dr. Green, what would you do differently if there was no risk of the magnitude that exists today for malpractice liability?

Dr. GREEN. Probably there would be a much more pleasant atmosphere in the office setting, the hospital setting, the doctor-patient relationship.

In reference to how my techniques might change, honestly, I must say that probably I would not be inclined to do as many sophisticated tests as I feel compelled to do because of the current situation.

Chairman STARK. Which kinds of tests?

Dr. GREEN. Ultrasound and sonogram tests can identify what is going on within the uterus without actually invading the uterus. I think we utilize these tests well, but I think we overutilize them for fear if we don't do them on multiple occasions, something might develop and that will come back to haunt us.

Chairman STARK. Fair enough. Dr. Corlin.

Dr. CORLIN. Thank you, Mr. Stark.

Chairman STARK. What would you do different in gastroenterology?

Dr. CORLIN. Three points, Mr. Stark. First of all, with regard to your client-physician data to indicate that the rate of increase of medical care costs in California has been less than that in the rest of the Nation and particularly at a time when within California the rate of increase of medical care costs has trailed below the rate of increase of other costs—and we will submit to you that documentation later on.

I will answer your question, but I don't think we should completely eliminate the risk of liability. Let me respond to your question if we theoretically did. I also would practice in an environment where I did a significantly reduced number of ancillary tests and x rays where I ordered them more than did them.

It is fairly routine to see x ray reports virtually always come back in circumstances where, if you can do either an echo scan or a CT scan or an MRI, or under circumstances where you can do

a scan or a barium enema, or one or another test that the radiologist responds to what he or she sees on the films but feels necessary to protect themselves by saying, if clinically indicated, correlation with, one of the others, would be indicated.

And this is clearly put on not in any way of interpreting the scan, but because in his or her memory, either he or she or somebody he or she knows was sued for not having done it. So there is this tremendous tendency to overutilize. I don't think any of us can quantify it exactly, but all of us can tell you very honestly that it does exist.

Chairman STARK. So if I understand this, Dr. Green and Dr. Corlin, you both save some premium dollars, some costs in malpractice premiums.

Dr. CORLIN. No. I never paid a penny in malpractice premiums.

Chairman STARK. You don't buy it.

Dr. CORLIN. I have it. My patients pay it.

Chairman STARK. That is all right. Then you are suggesting to me that you would lower your fees by the amount of the savings—I like that idea. That makes this exercise even more interesting.

Dr. CORLIN. In our office, what we do on an annual basis, with the obvious exception of Medicare where we can control it, we take a look at our year-to-year changes in overhead and we factor in four costs: What increases we have had to give in salary to our employees; how our rent has changed; we have five or six high volume supply items we buy, what the cost of them has changed; and how our liability insurance premiums changed.

And fortunately in California, that virtually has always been a zero, or in several of the past 10 years, it has been a negative which has helped to offset other increases. We factor that into our overhead.

Chairman STARK. Dr. Green, I presume that the only advantage to you and to your patients would be the reduction in the premium in that you don't participate in the costs or billings for sonograms or ultrasounds? So basically, your patients' costs would be adjusted at most by their share of the premium and the cost of the tests would be something that the insurance companies or whomever pays for the costs of the sonograms would save. It wouldn't affect your patients' costs? Is that correct?

Dr. GREEN. No, sir. No, sir. That is not correct. It would certainly save on the entire cost of the health care bill for that patient.

Chairman STARK. But not insofar as your billing them. You don't bill them for the ultrasound or sonogram?

Dr. GREEN. No, sir.

Chairman STARK. I am saying the only change in your billing to the patient would be whether or not you would choose to adjust whatever savings come, which in your case would be substantially more, I suspect, than in Corlin's.

Dr. GREEN. That is correct to a point. My philosophy for the office: If my malpractice insurance goes up, then the office fees do. If the malpractice premium stays the same, there will be no change. If the malpractice premium goes down, then the cost of having a doctor such as me take care of you will go down.

Chairman STARK. I like that. That makes good sense to me. Will the hospitals do the same thing, Mr. Leech.

Mr. LEECH. Mr. Chairman, the entire copy of services that are rendered by a hospital would include both the personnel liability issues, which would relate to nursing and other kinds of individuals, not physicians who are typically in the—I am speaking of a situation where hospitals don't have employed physicians.

That component goes into the billing, as well as additional kinds of equipment that may or may not be necessary, depending upon the treating physician's use of equipment. So to the extent that we are required to have or end up with fewer costs associated with liability insurance premiums, it relates to both personnel and equipment.

And in determining what charges we will make to the public, clearly the hospitals would take liability costs into consideration in determining what their ultimate charges would be. I feel to the extent the premiums went down, at least as far as AHA hospitals are concerned, as well as clients that I have, that that would be a significant portion of any reduction that could be made directly to patients for hospital services.

Chairman STARK. So you would favor reducing the costs to the patients or the insurer to the extent you could identify a savings from reduced premiums?

Mr. LEECH. Absolutely.

Chairman STARK. Great. Thank you.

Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

Dr. Corlin, your statement on the second page in which you say, we submit that avoidable mistakes are never acceptable on the bottom when you are talking about the question of negligence, and it is not just incompetent doctors. We have talked primarily in terms of the changes in malpractice in terms of costs, dollars and cents.

The thing I guess that gets me more excited as a nondoctor and a nonlawyer, is the fact that what I am beginning to see and I think the California plan helps offer that a little bit, is the positive things that can occur in the way in which doctors relate to patients if we can make changes in malpractice and the way in which doctors relate to doctors.

Because if we could agree, and everyone would with that statement, one of the ways to avoid avoidable mistakes, rather than punish in terms of a financial disincentive, would be increased communication, ongoing understanding that education is valuable inservice and otherwise. And guidelines which, if disseminated, seem to be acceptable, especially as indicated by the professionals themselves, can actually increase the quality of care for more people.

And that as you indicated in terms of the tests and you, Dr. Green, as well, the sad thing is that the current condition tends to play down the interpretive ability of that doctors have from knowledge and experience and substitute a series of ongoing tests which cost money, but probably don't really change what you are going to do in the end. And that, in fact, reduces your opportunities for that interpretive ability that, after all you went to school, you spent all those years practicing.

But having said that, let me ask you, you several times, Dr. Corlin—and incidentally, you are from California and you practice in California and you like the MICRA structure that you have in

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California. I am thinking about introducing a bill which will closely parallel the California structure as a model that people can react to.

One of the things I am thinking about from the California model, and I would invite your reaction, would be to eliminate the joint and several liability aspect. That is not in the California law. Would you consider that a plus or a minus?

Dr. CORLIN. Several years ago, in California, we passed proposition 51, Mr. Thomas, which did eliminate joint and several liability for the noneconomic damage portion of an award. We supported that effort. The major beneficiaries of that were municipalities and utilities. That individual component in and of itself affects physicians, and I would believe hospitals, but certainly physicians very, very little.

I think there was very clear evidence that municipalities and utilities were major beneficiaries. I think as regards to medicine, it is a very small point by itself.

Mr. THOMAS. The other concern I have is when someone asks, all right, changes have been made, show me in dollars and cents where it has made a difference. Especially if you are talking about a State like California in terms of population, not just the size increases, but the makeup of population as it changes, California is not static. That is true in other areas as well.

We heard from the GAO in the panel prior to yours that, in their surveys of States attempting to change relationships under malpractice and the tort reform areas and others, that they didn't see any evidence that current laws dealing with restraint of trade, antitrust made any difference at all.

If you are in a structure and perhaps Mr. Smarr might want to respond to this as well, in which we are looking for a solution within the profession, either doctor to doctor or hospital to hospital or doctors to hospital. Have any of you in discussions with your colleagues or looking for solutions found that you were bumping up against restraint of trade or antitrust in trying to move forward with solutions that you thought were good and worthy but couldn't?

Dr. CORLIN. Yes, sir. I can give you two examples, one of which happened at my hospital and one of which happened elsewhere within southern California. We had within our department, a gastroenterologist, one physician who on audit of charts several systems of concern to the remaining members of the gastroenterology section, fell out of audit.

We held a meeting of the section. We invited this one particular physician to come and we presented these results. This particular physician was particularly argumentative, and we were very careful to be very gentle in the way we addressed it, indicating that we were concerned about helping him specifically to set up a proctory situation.

The response of this physician was you are just trying to interfere with my practice. You are trying to steal my patients from me. I am going to get my lawyer. This is an antitrust issue and also, by the way, you are only attacking me because I am a member of a minority. The fact that with one exception, everybody else in the section was a member of a minority, too, seemed to be lost on him.

Those were the two issues raised and it really chilled our ability to get voluntary compliance with restrictions of this physician doing a couple of procedures until we could help him pick up the skills he needed.

Secondly, there is an obstetrician-gynecologist in Los Angeles, an extremely litigious person who wound up already suing seven or eight different doctors who testified against her, so I will confine my comments to what is in the public record. She was accused of charging between up to as much as $40,000 for hysterectomies, that is not an error in my reporting. It is an error in what she did, obviously.

The medical board held a hearing for a variety of reasons including which she had been kicked off the staff of more than one hospital and they concluded there were at least six reasons, any one of which would result in her losing her license and for all six of those reasons, they ordered her license revoked.

By playing various games with the courts, which are beyond my ability to understand the details of, 3½ years later, she still is practicing at a little dinky hospital that I wouldn't let my dog go to, but she is still practicing including going on television and TV talk shows and so on. It is a circumstance where the physicians in the community want to police ourselves but have been unable to do so.

Mr. THOMAS. If you are in California, you like what California is doing. Nevertheless, I believe you testified you think there should be a Federal solution to the malpractice.

Dr. CORLIN. I think Federal solutions would do two things: Number one, it would protect our California law because attempts will be made to dismantle it, we are sure; and secondly, there have been numerous attempts throughout the rest of the country to adopt the California model which have met with only extremely limited success.

And what we would advocate would be the combination of California MICRA law, and if the Maine experience bears out to prove to be as beneficial as it is hoped to be, adding that to it on a nationwide basis.

Mr. THOMAS. Dr. Green, I assume you would prefer a Federal malpractice change, given your testimony?

Dr. GREEN. Very much so. We don't have a sectional problem, so we can't come up with a sectional solution. The 50 individual States are trying their best to do something right for the people who need medical care is not working. We need a Federal solution to a nationwide problem.

Mr. THOMAS. And finally, might I, with the physicians finally deciding that the only way that they can get reasonable prices on the risk question was to create their own insurance companies, the administration's suggested solution of an industry-wide, I understand Kaiser Permanente requires mandated arbitration if you are going to be within that structure.

Is that in part because the doctors are basically employees of the structure, and in what way as physicians insuring physicians would they believe that the industry-based malpractice model would be sufficient for their concerns about protection from suits? Do they like it? Is it adequate?

Mr. SMARR. An industry-based model as in enterprise liability?

Mr. THOMAS. Fine.

Mr. SMARR. No, physicians are not comfortable with that. They are very concerned about the interplay between the business venture of the accountable health plan, vis-a-vis their individual rights to practice and to defend their actions. Most, in fact, I think virtually all of other member companies, the policies they issue have consent to settle clauses in them which is somewhat different than the commercial market.

And physicians are very interested in when carriers settle their claims. And the practice has been that if the claim, if you can settle it out for $5,000 and not worry about litigating the claim, then the commercial carriers will do that. That is an economic settlement.

Our companies on a whole will not do that. They will spend the $26,000 it takes to go to court to defend a claim, and the physician plays an active role in that and the physicians are very interested in controlling their liability situation.

Mr. THOMAS. What about the number of claims based upon the difference in terms of the way it is done? Is there any evidence that the willingness to go all the way to extend the money to vindicate yourself produces fewer claims.

Mr. SMARR. We believe it does. I have personally seen in Pennsylvania where the trial bar was very aware of the substance or position of a carrier and they incur expenses to bring a claim, and when they only prevail on one out of three, they have to be very careful about the claims going on.

Mr. THOMAS. Mr. Chairman, thank you very much for the generous time.

Mr. LEVIN [presiding]. Mr. Andrews.

Mr. ANDREWS. Dr. Corlin and Mr. Leech, clearly the signal has been given that there is going to be malpractice reform and tort reform in this overall umbrella of health care reform. Everyone recognizes that this current system we have contributes to the excessive costs and that a change is needed, including Mrs. Clinton. She spoke eloquently on numerous occasions about the need for tort reform.

Let me ask you, though, Dr. Corlin and Mr. Leech, to address a hypothetical for me. Let's assume hypothetically that the patient is under a doctor's care in the hospital and because of the doctor's actions and negligence, and because of the hospital's negligence, that person is terribly disfigured, paralyzed, unable to perform any work, any service, is turned into a horrible defaced patient and is a young person, the file would be so egregious that it would make both of you angry to read the file.

Are you suggesting that in a case like that, hypothetically, that punitive damages or joint and several liability wouldn't be appropriate?

Dr. CORLIN. First of all, it is my belief that the joint and several issue with regard to medical liability is an almost insignificant item. The history of where that has come into effect, as I said, there was a classic case in California. Very briefly, it was a 16-year-old who was drunk who took—got in her father's car which represented most of the family's assets, ran a stop sign, hit a boy on a bicycle, rendered the boy paraplegic. $6 million judgment. She

was found 99 percent liable. The city, and I believe it was Redondo Beach, was found 1 percent liable because a stop sign on private land over which the city held an——

Mr. ANDREWS. I am not interested—let me just, because I only have 5 minutes and I wouldn't want to overrun my time. I know anecdotally each of us can think of terrible situations where the joint and several liability aspects of our tort law are abused and we have crazy results that don't make a lot of logical sense. But let's go back to my hypothetical. Let's assume——

Dr. CORLIN. I don't think joint and several is a big issue.

Mr. ANDREWS. Just 1 second. I didn't ask you whether you thought it was a big issue or not. I asked you, in a case, if you opened a file and you read that file, it would make you angry at the contributors to this patient's predicament. In the suffering that this patient would have to endure for 30 or 40 years the remainder of their life would be insufferable and would make you mad at not only the actions of the doctor, but the hospital or other people involved in the chain.

Are you saying, in that particular—in that kind of hypothetical case, joint and several liability would not be appropriate and that punitive damages would not be appropriate?

Dr. CORLIN. I don't know enough about the issue of punitive damages to respond and I am not trying to cop an issue. It is something I am not familiar with because they almost never are involved in professional liability. I can tell you specifically, to your other point, Mr. Andrews, I don't view the waiver of joint and several or whatever the technical legal term is as a significant issue. It is not a part of what the AMA is asking for in tort reform.

Mr. LEECH. May I respond, Congressman? First of all, we know that mistakes are going to be made, and you obviously described one which is a very egregious mistake. And let's assume there is negligence and something was done very improperly by a physician and by nurses. We are not taking the position that people who have been injured by the legitimate—not legitimate, but by actual—negligence of provider should not be cared for.

The question is: Who should pay for it and what is the most efficient way in an overall aggregate way to take care of those kinds of problems because, unfortunately, those problems will continue to exist.

What we would look at in your example would be that to the extent that the hospital had active participation in the negligence, that clearly they ought to, on the basis of the proportion that was assessed by the jury, be responsible for their share of whatever those damages are.

To the extent that the hospital was extremely egregious and irresponsible in dealing with the patient, perhaps punitive damages might be appropriate under those circumstances. Because punitive damages are not to compensate victims, they are to penalize the violator. And the joint and several issue is, well, is there enough money to go around to adequately and equitably compensate a person who has been legitimately injured?

And under those circumstances, if the physician had no insurance, let's say, or limited insurance, then perhaps it would be appropriate to have the joint and several responsibility apply to the

hospital. But in the overall sense, in a broad policy sense, what AHA is saying is that we would like to ensure that hospitals are held responsible for their part of the negligence and other providers are held responsible for theirs, and not to use hospitals or other networks as a deep pocket.

If—may I? Because I think this gets into the real issue of how we are going to reform this health care system. We have talked about enterprise liability. To the extent that an enterprise involves a vertically integrated set of providers, let's say physicians, long-term care, hospitals, acute care facilities as well as outpatient clinics, perhaps an insurance company, and they are—all of those elements have an economic risk in that network—then as long as there is economic risk of each one of those elements, then that network itself can in effect police itself and that will provide, we feel, a much more—much more assurance of delivery of quality health care than the fragmented system we have now. Because we end up pointing fingers at one another and that doesn't solve our overall problem.

Mr. ANDREWS. But to recap, because the red light is on, so I want to finish so others can ask you all questions. As you are saying, the American Hospital Association is not opposed to punitive damages in an appropriate case or joint and several liability in an appropriate case. I guess really that is my—that is the point of my question.

Mr. LEECH. Yes, subject to deferment to my counsel.

Mr. ANDREWS. Dr. Corlin, in an appropriate case, would punitive damages be acceptable to the American Medical Association?

Dr. CORLIN. We don't have specific policy that I am aware of because in none of the discussions concerning liability has that issue come up. And I can't give you an answer now. I will see to it that our staff provides you with a written answer very quickly.

Mr. ANDREWS. In your opinion, should she be?

Dr. CORLIN. I think if there is something which is so egregious as opposed to a physician making an error of judgment or a mistake, for instance, somebody operating while drunk, I think under those circumstances, as my personal opinion, I think it might well be.

Mr. ANDREWS. Thank you very much, Mr. Chairman.

Mr. LEVIN. Mr. Grandy. I think Mr. Grandy was here.

Mr. GRANDY. I was here with you. I am going to yield to Mrs. Johnson at this time. She has to leave, so I will yield my time to her.

Mrs. JOHNSON. Thank you, Mr. Chairman. And I thank the panel for your really excellent testimony and for your kind references to my legislation.

Just for your information, when I first introduced malpractice legislation starting 3 years ago, we did have a hearing and the polarization of opinion at that time, and the lack of real depth of understanding of how serious a matter this was, was very evident.

And so not only have Members of Congress come a long way where I think most Members realize we really have to do something about this, but also the public in general in America has begun to understand the systemic problems that have been created by our system of malpractice.

So I certainly join you, Dr. Green, in feeling that we have to move on this immediately and I would call Members' attention to something in your testimony that unfortunately you didn't get time to air. But the story about the West Virginia obstetrician who at 35 had to leave the practice of obstetrics because she lived in a poor area and could not pass the costs on to her patients is a very sobering example of the impact of this problem on availability of services in poor areas.

I wanted to commend you, Dr. Green, in your testimony on the proposal for a grant program that would help pilot some innovative solutions to some aspects of this problem. But no one has discussed the burden of proof issue that you raise in your testimony on page 6. That is a particular problem for obstetricians who have not been able to provide prenatal care. Some obstetricians are required to perform the deliveries without having had the opportunity to provide prenatal care.

Could you enlarge a little bit on that issue of burden of proof?

Dr. GREEN. The court system says that the preponderance of the evidence, meaning that if the majority of the evidence indicates that there has been some malpractice committed by the physician. There is a problem with delivering a patient who you have never had the opportunity to provide prenatal care for during the 9 months of prenatal care.

There are many problems that might come up and you haven't had the opportunity to handle those problems, but they are being dumped on your door step at the time of delivery. And one does the best that one can, but you can't change what has already come about. So we are suggesting that there be more detailed and critical evidence be required for winning such a suit rather than just a general preponderance of the evidence, as in other cases.

Mrs. JOHNSON. A higher standard of evidence?

Dr. GREEN. Yes.

Mrs. JOHNSON. This leads to another question that I want to raise that hasn't been raised to this point, and that is the impact of our malpractice system on the dialog between the physician and the patient and what it has done to the level of trust and rapport that is necessary to high quality care.

Any one of you who would care to comment?

Dr. GREEN. My idea of being a physician was to be a good old Marcus Welby type doctor. Everybody in the town knew you. You took care of everybody. Everybody sort of loved you and respected you and you did your "doggonedest" to take good care of everybody. That is just not reality nowadays. I think that some patients—and I am not saying this prejudgingly—probably see the adversarial relationship as very profitable sort of maybe playing Lotto America.

Mrs. JOHNSON. That is interesting. Can you give any examples of that?

Dr. GREEN. I have had patients say to colleagues of mine, Dr. X, it is not really your money, so if we sue you, and you have to pay us $1 million, it is not coming out of your pocket. But they fail to see the bigger picture. That it is invariably coming out of all of our pockets at some point. We are all liable to pay at some point along the way, and because the money might be coming directly from the

insurance company as opposed to physically out of the doctor's pocket does not justify the action as far as I am concerned.

Mr. SMARR. I would like to speak to that, if I could. As a patient, when I or a member of my family goes to see a physician, they see where I work. Until a year ago, I worked for a medical malpractice insurance company and they treat my family with utmost concern over the liability situation.

I have been told point-blank, because you work for a medical malpractice insurance company, I have got to cross every "t" and dot every "i" and get it right. And I can see that adversarial relationship. It is really not adversarial, but a situation of great caution.

Mrs. JOHNSON. Dr. Corlin.

Dr. CORLIN. I would agree with all of those items. I think we are excessively cautious at times, and also it has interfered with the physician-patient relationship to the extent that we have to pass along those fees. When a neurosurgeon in Miami has to pay $185,000 a year and the ordinary surgeon does 120 operations a year, that is $1,500 per case that has to be added. That is an added burden on the patient.

And when the Medicare fund has to pay twice as much in deviation from average, in the reimbursement under the RBRVS in Florida as they do in California, that is a problem not just for the individual doctor-patient relationship, but for the cost of the Federal Government.

I would like to see those things corrected. You know, we hear a lot about comparing the United States with other countries. Our malpractice premiums are 8 times what they are in Canada, 25 times what they are in England. And although the way we pay for health care is different, the health care we deliver is virtually the same and the standards of care are within inches of each other.

And I simply refuse to believe that doctors in the United States are 8 times as bad as doctors in Canada or 25 times as bad as doctors in England.

Mrs. JOHNSON. Lastly, because my time is up, Dr. Green, who is going to take over your practice when you retire? Do you have younger partners? Are there other younger obstetricians in your neighborhood who are going to absorb your patient load?

Dr. GREEN. I am in solo practice, so I have no one expected to take over my practice. I would like to consider myself still a young doctor with many years yet to go. When you finish your residency program and you are attempting to go into practice nowadays as an obstetrician-gynecologist, it is just prohibitive. You almost have to commit yourself to a managed care program because there is no way you can come out of a residency and assume all of the overhead that would be necessary for you to open up your private office. It just is not financially feasible.

Mrs. JOHNSON. Do you see in Washington, D.C. any difficulty in attracting obstetricians to high risk areas?

Dr. GREEN. Well you know, Mrs. Johnson, that is a whole other can of worms. And I am not being a wiseguy in saying that, but here in Washington, we have no tort reform and I am not saying that to be snide, I am saying that because it is a fact. And so when a person can just go to Northern Virginia or to Silver Spring or

Wheaton or Bethesda and open up a practice and still be in the same metropolitan area, but have cost of providing the care that they want to provide is significantly lessened. This is true in Maryland and Virginia because there are some type of tort reform legislation there.

Mrs. JOHNSON. Powerful case for national reform. Thank you, Mr. Chairman.

Mr. LEVIN. Let's see. Let me withhold questions until after you, Mr. Grandy, and Mr. McCrery here.

Mr. GRANDY. Thank you, Mr. Chairman.

Dr. Green, I have a quick question for you and then I think a longer question for Dr. Corlin and Mr. Leech but I want to go back to something that Chairman Stark mentioned in his inquiry of you.

I got the impression that he was probing to find what the indirect savings would be through reduced premiums by malpractice reform, particularly on you as an obstetrician. But is it not also true that there would be direct savings in a lot of these tests that you refer to and make during the course of an obstetric examination, have copayees so that people who do not have to have those tests because you are not feeling obligated to refer them to labs for those tests are paying in most coinsurance situations 20 percent off the top. So there is a direct savings involved, too, is there not?

Dr. GREEN. There is—that is direct savings to the patient in out-of-pocket money. And that is a direct savings to the system in general if I don't feel compelled to order as many tests as I have been because of the scenario now.

Mr. GRANDY. I just thank you for that because I think we have established that there are indirect savings. But I also wanted to get on the record that I think, in most insurance situations which would involve these laboratory tests, there would be direct saving to the patient.

Dr. GREEN. Yes, there would.

Mr. GRANDY. Now, Dr. Corlin, in your capacity as representing the AMA, and Mr. Leech in your capacity with the AHA, I would like you to answer this question for me. And I want to quote something that Mr. Thompson said in his GAO report and this goes to the heart of the antitrust question.

He says,

State medical boards which are responsible for imposing sanctions on physicians found to be incompetent or impaired by debilitating conditions such as alcoholism or drug abuse or mental illness are often criticized for not doing more. But before they impose sanctions against physicians, negligent actions or impaired performance must be reported to them. To date many health care providers have been reluctant to speak out against their colleagues.

So my question to you is twofold: What do you in the physician and hospital community need to do to convince us as policymakers that you are capable of stepping up to that responsibility and policing yourselves; and two, what help in terms of antitrust reform or reworking of laws at the Federal level do you need?

And in addition to a uniform liability standard, does that imply some kind of uniform practice guideline standard that would perhaps be nationwide, and to what extent do we need to modify the information that is now coming forward through the National Practitioner Data Bank?

I have left you a lot of things to answer, but I did that on purpose so that you could have the rest of the time because I really want to pursue this antitrust issue from the physician point of view. If we can't trust you to police yourselves, I think we are stymied at the starting gate on malpractice reform and physician responsibility.

Why don't you go first, Dr. Corlin.

Dr. CORLIN. Thank you, Mr. Grandy.

First of all, in California we have what is referred to as 805 reporting whereby every hospital staff that takes action to restrict a doctor's privileges for other than administrative reasons, that is, you indicate your choice, but for any quality or ethical basis we restrict a physician's privileges, we are required to report that to the State board. I think that is a very good item to do and we, in fact, are making all of our committees aware of that.

We have had some difficulties with our State board. You may have seen on 60 Minutes, there was a horrendous scandal where 11 employees of the State board were basically sync testing discipline reports. That is something that is out of anybody's control.

One of the things we would like to see is that physician license fees are kept in the State board. In California, the medical association is currently suing the State because we supported an increase in physician license fees to allow the board to hire more investigators and the State, which is in terrible financial condition then took the reserve money out of the medical board to use it in the State general fund which is going to impair the ability of the medical board to hire investigators.

The medical associations don't, unfortunately, have any legal authority and indeed virtually every time notwithstanding the ACQIA, every time we try to deal with an issue of a physicians quality and our concerns, we come up against allegations of antitrust. And it just incredibly put a stop to the process of the disciplining.

We need some very substantial help. Obviously, we still need to afford the physician protection from being victimized inappropriately, but we really do need those areas where the medical associations can proceed on complaints, both with regard to fees and with regard to quality issues, without fear of being called to task for antitrust which is virtually every time.

Mr. GRANDY. Mr. Leech.

Mr. LEECH. Mr. Congressman, I think we need to set the stage as to what generally the facts are. First of all, in most cases, physicians are independent and not employed by the hospitals. That being the case, then the hospitals need to encourage their own independent contractors to perform a peer review process at the hospital level and most States have peer review processes.

However, those protections can be brought into question in an antitrust action because, if there are economic motives that are driving decisions that relate to peer review activities by physicians concerning another physician on a staff, problem can arise. There have been numerous cases that have been filed. And I don't recall the name of the case in Oregon, but there was one that came up within the last 4 or 5 years that may have had some egregious

facts, but it has enabled physicians who were sanctioned by their fellow peers to continue an antitrust action.

Now, the biggest problem that we have here is that we don't have the physicians and the hospitals together in a single organization and that creates antitrust issues because you have independent entities that can be economically disadvantaged by the action taken by their peers.

I think that is what has spurred numerous antitrust actions and especially as the system cranks down and hospitals are looking more carefully at their medical staffs, that it may be—I think it will be exacerbated in the future as physicians who are questionable in their practice may very well find that they have no place to practice, which will cause them significant displacement and lack of any place to practice their trade.

What the AHA has suggested in the networks or community care networks, is that to the extent we can put providers together and give those providers a collective economic interest in providing health care services, they will more effectively police themselves so that physicians, as I mentioned before, hospitals, and various kinds of other providers in an organization who will be jointly at economic risk will do two things:

First of all, they will have the legal ability to monitor themselves and it will be in their economic interest to provide better quality care. And secondly, as data is produced by those networks, they can compare themselves against a standard of other competitive kinds of networks, which will enable a constant improvement of the care.

Now, creation of the networks themselves is where I feel that the most necessary reform of the antitrust laws or at least alleviation of the antitrust pressures is needed.

Mr. GRANDY. Mr. Leech, I have gone way over my time. I appreciate your answer, but I would also like to ask of you gentlemen, if you could put some of this down in writing, it would be very, very helpful to the members of committee. I would ask you to do that.

And Mr. Chairman, thank you for your indulgence.

Mr. LEVIN. Thank you, Mr. Grandy.

Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman.

In particular, I wish that you would supply us with antitrust problems that you see affecting the issue of medical malpractice reform and what are other areas of antitrust or other areas of the medical field which antitrust affects and are we aware of those.

Dr. CORLIN. We will submit that to you in followup written testimony.

Mr. MCCRERY. Thank you.

Mr. LEECH. As will we.

[The following was subsequently received:]

American Medical Association
Physicians dedicated to the health of America

1101 Vermont Avenue, NW 202 789-7400
Washington, DC 20005

August 6, 1993

The Honorable Fortney Pete Stark
Chairman
Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
239 Cannon House Office Building
Washington, DC 20515

RE: Health Care Reform: Issues Relating to Medical Professional Liability

Dear Chairman Stark:

The American Medical Association (AMA) was pleased to testify at the hearing of the House Ways and Means Subcommittee on Health on issues relating to medical professional liability within the context of the current debate on health system reform.

At that time, members of the Subcommittee asked the AMA to provide additional information regarding the following subjects: (1) the reduction in health care costs in California since the 1975 enactment of the Medical Injury Compensation Reform Act (MICRA); (2) the AMA's views on joint and several liability; (3) the AMA's views on punitive damages; (4) the appropriate role of state medical boards, especially with respect to reporting issues; (5) antitrust impediments to disciplinary activities by the medical profession and their impact on medical liability reform; and (6) the impact of practice parameters on the medical liability arena.

The attached analysis and statistical data are offered in response to the inquiries of the Subcommittee. We look forward to working with you to achieve viable solutions to the complex problems that pervade the medical liability environment, impact on health care costs, and perpetuate the inefficiencies and inequities of our civil justice system.

Sincerely,

Richard F. Corlin MD

Richard F. Corlin, MD

Attachments

all 60 168-178

HEALTH CARE REFORM: ISSUES RELATING TO MEDICAL MALPRACTICE

Since the enactment of the 1975 California Medical Injury Compensation Reform Act, have health care costs been reduced in the state?

Current evidence suggests that California's MICRA reform has helped control the state's health care costs. From 1984 to 1986--the worst years of the last liability crisis--physician fees nationwide increased 13.1%, but only 9.2% in California. (Figure) In 1991, the California medical care services index was lower than the national average, although other state consumer costs were climbing at a higher rate than the national average. (Figure)

On a nationwide basis, medical liability premiums constituted the fastest growing component of physicians' practice expenses in the 1980s. In California, however, MICRA reform succeeded in stabilizing and actually lowering these insurance costs. (Figure). When MICRA was enacted in 1975, the medical liability premium costs in California were the highest in the nation. Today, they are one-third to one-half the costs of premiums paid in states without a MICRA-like cap. (Figure) In addition, the California reforms were not indexed to inflation, and, therefore, succeeded in lowering the real cost of liability insurance. A linkage to the Consumer Price Index would have doubled the limit every ten years, bringing it to over $1 million by the turn of the century. (Figure) Wisconsin abandoned its inflation-indexed ceiling on noneconomic damages as it appeared to be having this effect.

What are the AMA's views on joint and several liability?

The AMA supports the elimination of joint and several liability.

What are the AMA's views on punitive damages?

The award of punitive damages introduces a quasi-criminal element into medical liability litigation. This factor is not always made clear to juries hearing medical liability cases. Once rare in medical malpractice litigation, allegations of "outrageous" conduct that merits a punitive award are increasing. Because punitive damage awards may not be covered by liability insurance, the mere assertion of such a claim often prompts physicians to settle even defensible cases in order to avoid exposure of personal assets. The AMA believes that punitive damages should only be awarded when the party alleging such damages meets the burden of proving an intent to do harm by "clear and convincing evidence".

Under the current system, sympathy on the part of the jury often results in inflated punitive damage awards. Since the plaintiff's attorney customarily would receive at least one-third of the punitive

damage awards, this would ill serve the public policy goal of deterring extreme and reckless conduct upon which the existence of punitive damages is founded. The AMA urges that any federal legislation incorporating provisions addressing punitive damages must place a strict limitation on the amount to be awarded. In addition, a rational relationship must be established between the amount of punitive and compensatory damages. Thus punitive damages should not exceed the full amount of compensatory damage awards. Any legislative proposal must, therefore, establish guidelines for determining whether punitive damages are to be awarded in health care liability actions, as well as formulate criteria for determining the amount of punitive damages.

What is the appropriate role of state medical boards, especially with respect to reporting issues?

Health care professional associations and health care facilities should be required to notify state licensing and disciplinary boards when disciplinary action is taken against a health care professional. Health care professionals should also report personal knowledge of any conduct that they reasonably believe constitutes grounds for disciplinary action to the state medical board. Information systems should be expanded to allow prompt transfer among jurisdictions of pertinent licensure and disciplinary information about health care professionals.

The AMA supports the dedication of health care professional licensing fees to increase the effectiveness of state medical disciplinary boards. Adequate funding of these boards would allow for appropriate investigations of complaints regarding quality of care and/or the competence of health care professionals. We also support the ability of states to enter into contracts with local professional societies to assist in investigating consumer complaints. The State of Maryland has recently implemented such a system, in which local committees of physicians operating as ad hoc agents of the state peer review complaints and make recommendations for action to the state licensing authority. Protected from the threat of antitrust exposure by a grant of sovereign immunity, programs such as the Maryland initiative have the potential to significantly enhance the resources of licensing and disciplinary boards, as well as the peer review activity of local medical societies.

Federal medical liability reform initiatives that encourage local quality management efforts to promote patient safety and quality of care should be implemented. The Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), health care institutions, managed care organizations, professional societies, state licensing and disciplinary boards, and medical liability insurers have created a number of innovative programs to promote quality. These approaches include risk management education, professional oversight and review, and disciplinary activities.

In the AMA's view, what are the impediments under antitrust law and enforcement activities to disciplinary activities of the medical profession, and their impact on medical liability reform?

State and county medical societies face a number of obstacles in conducting disciplinary activities. Lack of funding is a serious problem, and the demands of legally required procedures are increasingly complex. Fear of litigation, including antitrust litigation, is one of the primary causes cited by medical societies when asked what problems preclude them from being more involved in peer review activities. Medical societies have been sued over adverse peer review decisions based on legal theories, other than antitrust, and the AMA is seeking protection for medical societies from other types of claims, as well as antitrust claims.

An antitrust lawsuit is by far the most feared type of legal claim, inasmuch as it represents the most expensive type of claim to defend against, with costs in excess of one million dollars in many cases. The high cost of potential litigation seriously inhibits the activities of state and county medical societies which are not wealthy organizations. Insurance that will pay for defense costs and judgments, moreover, is prohibitively expensive or simply unavailable. Therefore, activities that can lead to litigation, including peer review, are often avoided even if medical society leadership is confident that these activities are legal and would be performed in good faith. The cost of litigation, rather than the threat of adverse awards, acts as the primary deterrent. In antitrust litigation, the threat of treble damages, and attorney fees in the event of an adverse result, act as a further deterrent.

The experience of a large county medical society which does discipline members, Dallas County Medical Society, provides a good example. During the past four years, Dallas County has expelled three members and denied the applications of three potential members. Two of these actions have resulted in lawsuits that are currently pending.

With respect to addressing complaints about physician fees, most medical societies are concerned about the potential for federal prosecution. Medical society executives have become aware of the aggressive efforts by the Federal Trade Commission (FTC) and the Department of Justice (DOJ) to prosecute price-fixing in the health care industry and are fully aware of the potential for criminal penalties as well. Most state and county medical societies see the review of fee complaints as controversial and too risky to pursue in spite of current FTC guidelines. Current FTC guidelines allow fee peer review to take place if the following conditions are met:

(1) Participation in the fee peer review process by the physician who is the subject of the complaint must be voluntary. A medical society cannot compel a member who has been complained of to take part in a fee peer review proceeding.

(2) Determinations made by the peer review committee about a physician's fees must be advisory and must have no coercive aspects. The medical society cannot discipline a physician for charging a fee that is judged to be too high and cannot require that the physician lower the fee as a condition of continued membership.

(3) Peer review decisions must be based solely on the facts and circumstances of the case. Determinations about post-pricing decisions by the physician may not become generalized in future fee peer review decisions. The peer review panel may not look at past fee opinions to judge the validity of a fee being reviewed.

(4) Any opinions arrived at by the medical society may be shared with the complaining party and the physician complained of, but may not be disseminated to the membership of the society involved.

(5) The medical society may not develop predetermined fee schedules to use as a benchmark for evaluation of complaints about a physician's fee.

Some large and well-staffed county medical societies engage in fee peer review, but they are able to retain antitrust counsel and believe they understand the limits of the activity. Clarification must be provided in this area so that constructive efforts may proceed without the spectre of antitrust litigation.

On April 30, 1992, the AMA filed a request for an advisory opinion with the FTC seeking an alteration in FTC standards for fee peer review. Chicago Medical Society joined the AMA's request. The AMA asked the FTC to allow medical societies to compel members to participate in fee peer review proceedings and to discipline members who engage in fee gouging. We have not requested that medical societies be permitted to develop fee schedules or to disseminate the particulars of fee peer review proceedings to members.

The AMA further believes that private parties should not be allowed to sue medical societies or other physician organizations for good faith actions taken as part of quality assurance activities. The interests of individuals adversely affected by quality assurance actions can be protected by preserving the ability of government enforcement agencies to bring civil injunctive actions. Criminal prosecutions for actions arising from quality assurance activities should also be eliminated. Such immunity will reduce the potential litigation costs of quality assurance activities for medical societies to an acceptable level.

If the type of immunity requested by the AMA is not possible, then, at a minimum, the following changes should be implemented: (1) elimination of damage awards against medical societies that engage in disciplinary activities; and (2) recovery of attorneys' fees from the plaintiff when the medical society successfully defends a case.

Assess the impact of clinical practice guidelines on the medical liability arena.

At the present time, insufficient evidence exists to show that clinical practice guidelines can be developed in a manner specific enough to be introduced as an affirmative defense in medical liability litigation. Concerns arise that any governmental procedures utilized to endorse such guidelines may move too slowly to accommodate rapid changes in medical technology. If legal protection were afforded only to practices within government-approved parameters, medical treatment that embraces the newest scientific information may be discouraged.

Innovative local experiments with practice guidelines are now being tested in Maine, Minnesota, Florida, and Vermont. Physicians electing to participate in these demonstration projects will be able to assert compliance with practice parameters and risk management protocols as a legal defense in any medical liability suit brought against them during the years of the pilot programs. It is hoped that using practice parameters in this way will help to classify the standards of care applied by courts and discourage the practice of "defensive medicine" outside of approved parameters. The AMA believes that these state experiments should be supported by the federal government through the activities of the Agency for Health Care Policy and Research. By tracking the claims brought during the demonstration period, and comparing this data with data before the experiments took effect, appropriate determinations may be made on the efficacy of using practice guidelines as an affirmative defense.

The AMA believes that medical societies that engage in the development of practice guidelines,

technology assessment, and outcomes measurement and reporting activities should be protected from private antitrust lawsuits in order to avoid the potentially high litigation costs that inhibit such constructive activities. To this end, we have supported H.R. 47 which provides for an exemption from the antitrust laws for medical self-regulatory entities that engage in standard setting or enforcement activities designed to promote the quality of health care, including the development of practice guidelines, ethical codes, peer review, risk management, accreditationof medical education and hospitals, and technology assessment. Such legislation would ensure the continuation of constructive efforts by medical societies without threat of litigation. For example, California Medical Association (CMA) curtailed its technology assessment program in the aftermath of antitrust litigation by providers of services or products that failed to receive favorable opinions. While none of these cases resulted in an adverse judgment or unfavorable settlement, the costs of defending lawsuits became so great that the program was terminated.

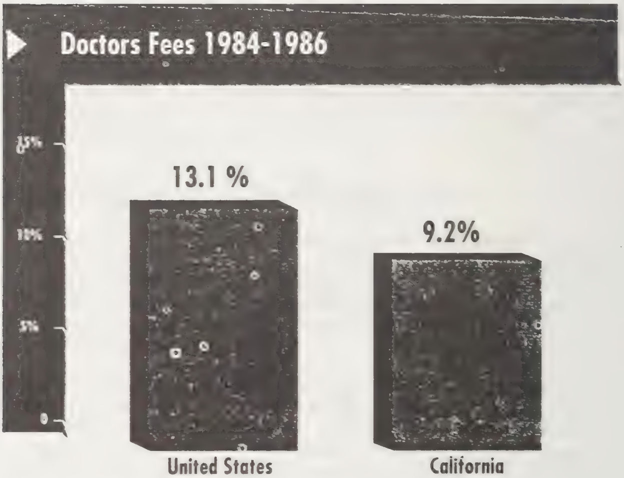
Q&A\CORLIN\LIAB.HRG

Figure 1

MICRA Helps Keep Californians' Medical Bills in Check

Without MICRA, Doctors' Fees Would Be Higher

From 1984 to 1986, doctor fees nationwide increased 13.1% — but only 9.2% in California. If California doctor fees had increased at the national rate during this period, the added costs to California consumers would have been $790 million.



*Note: MICRA was upheld by the California Supreme Court in 1984-85

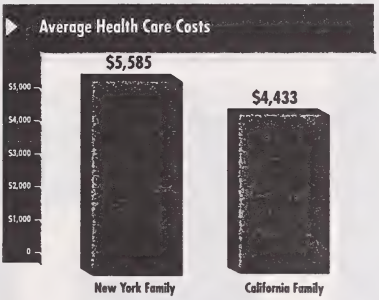
SOURCE: American Medical Association

Figure 2

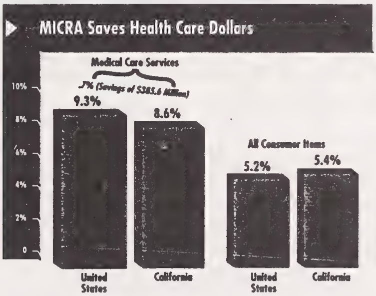
After MICRA: Real Results

MICRA Helps Control Medical Costs in California — Without MICRA, Medical Costs Would Be Even Higher

By controlling the cost of liability insurance, MICRA has slowed the increase of health care costs in California. As illustrated in the first chart, a recent consumer study by "Families USA" shows that health care costs for the average New York family in 1991 were $5,585 — compared to $4,433 for the average California family.



Further, as seen in the second chart, although consumer costs in California generally were higher than the national average in 1991, the state's medical care services index was lower. In 1991, California's medical costs increased less than medical costs for the nation as a whole, saving Californians $385.6 million.



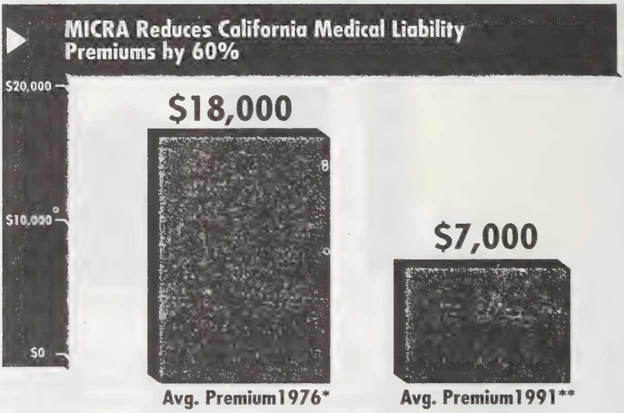
SOURCE:
1. Families USA
2. Source: Consumer Price Index for All Urban Consumers (CPI-U), 1989-1990, based on an average from the Los Angeles and San Francisco Bay Area indexes.

Figure 3

Insurance Premiums Cut

MICRA Has Cut Medical Liability Insurance Premiums by 60%

Before MICRA took full effect, California physicians paid an average $18,000 for liability insurance in 1976. By 1991, MICRA had reduced the average liability premium to $7,000 — **a 60% savings.**



— Shown in 1991 dollars

* $7,241 average premium adjusted to 1991 dollars on the December Urban CPI Index

** Dividends from 1990 deducted from 1991 average premium

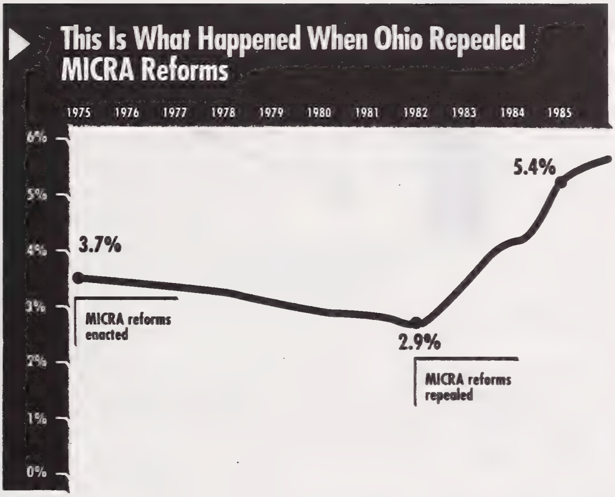
SOURCE: Physicians Insurance Association of America

Figure 4

Effect of the $250,000 CAP on Non-Economic Damages

Ohio Professional Liability Payments as a Percent of Payments Nationwide

Ohio adopted MICRA reforms in 1975, when payment of medical malpractice claims in the state of Ohio was 3.7% of the total paid out nationwide. That percentage declined to 2.9% from 1975 to 1982 while the reforms were in force. In 1982, the Ohio Supreme Court invalidated the $250,000 cap on pain and suffering, and by 1985 Ohio's percentage of nationwide claims had climbed to 5.4%



SOURCE: Tillinghast

Figure 5

Effect of Indexing the $250,000 CAP

Index the $250,000 cap back to 1975, and it would raise the cap to $700,000 today. Based on average increases in the CPI over the past 16 years, the cap would then double every ten years, sending the cap spiralling out of control, eliminating its effectiveness in stabilizing liability and health care costs.

* based on actual changes in CPI

** based on average of actual CPI 1975-1992 of 5.61%

SOURCE: U.S. Department of Labor
Bureau of Labor Statistics

All indications from the White House task force on health care reform are that this country's future health policy will include the notion of accountable health plans (AHPs), or networks of providers. While the exact formation, structure, and operation of AHPs are yet to be determined, the creation of AHPs raises various antitrust issues. If in fact Congress embraces this idea as a basis for health care reform, the following consideration will need to be addressed.

First, although the expectation is that AHPs will compete with each other to provide services, in some markets (such as rural areas) only one network will exist due to geographic location or limited resources.

Second, networks likely will involve collaboration among providers that are otherwise competitors of each other, requiring agreements that may be subject to antitrust challenge.

Third, restrictions on competition among network members may be challengeable as "unreasonable restraints of trade." For example, members may agree that all nonemergent lab work will be referred to one network-designated lab.

Fourth, formation of efficient AHPs will almost certainly result in some providers being excluded from the provider network. Such exclusion may be viewed as unreasonable and challengeable as a "boycott" under antitrust laws.

Fifth, agreements between competing providers to allocate services among themselves could be viewed as "market allocation," a per se violation of the antitrust laws. For example, two hospitals may wish to avoid duplication of services by agreeing that each will buy and use different equipment, rather than each buying and using similar equipment and competing for business.

AHA believes that if national health policy is to be founded upon collaborative networks of providers furnishing care at the community level—as we believe it should be—then, the above antitrust issues will need to be dealt with in the context of health care reform.

Mr. McCRERY. I want to quote the GAO testimony, too. They say that in discussing the main initiative, physicians' primary motivation for practicing defensive medicine is the uncertainty about the standard of care to which they will be held accountable if patients allege that injuries resulted from the physician's failure to meet the acceptable standards of care.

Fearing such allegations, physicians may be motivated to perform unnecessary tests and procedures to build a good record in the event they are sued for medical malpractice.

Dr. Corlin and Dr. Green, is that your appreciation of the situation for physicians today?

Dr. CORLIN. It is exactly the situation, Mr. McCrery, and I do a modest amount of the expert witness work, if I might say, on both sides. I take a case from whomever sends it to me. And nothing is more frustrating than to be involved in a situation where you have got duelling expert witnesses.

That is not the way issues should be decided. They should be decided objectively as to what is the standard of care. And I think that we are all looking to see what comes out of the Maine experiment. If it does give positive results, I think it will help in, number one, reducing what I refer to as the frictional cost of the litigation; number two, getting away from often outrageous statements and some pseudo signs at times that are claimed as the standard of care.

And number three, enabling both physicians and patients and the lawyers and others who represent the potentially injured and injured patients with the potential suit to determine did this care deviate from the standard and I think it will help everybody involved.

Mr. McCRERY. Dr. Green, do you agree?

Dr. GREEN. I agree. Our technology is such today that patients expect that you are going to have the ability to do each and every

test to rule out everything. And that does put a burden on the system financial-wise.

Mr. McCRERY. And we heard testimony earlier from GAO also with respect to the Harvard affiliated institutions study, that there were no sanctions that they were aware of, that would be imposed upon physicians who did not follow the practice guidelines in the risk management arrangement in those institutions, but that their experience was that they did follow them from peer pressure.

So is it your opinion, I am leading the witness here, but is it your opinion that if we could combine that peer pressure with some carrot like immunity from suit or an affirmative defense, perhaps, in a lawsuit, that the response would be even stronger?

Dr. CORLIN. I believe so, yes.

Mr. McCRERY. Dr. Green.

Dr. GREEN. I agree. I think that there is no profession that is perfect, but I think basically doctors want to do the right thing, and if you give them the opportunity, they will.

Mr. McCRERY. So with that strong combination of peer pressure and the carrot in the form of an affirmative defense, you would conclude that in fact defensive costs could be curtailed?

Dr. GREEN. I think they could be decreased substantially.

Mr. McCRERY. Very well. And now quickly, Mr. Leech, I don't want to leave you out here because Dr. Corlin, I think, led you astray earlier in speaking of joint and several liability. I think you anticipated his response and nodded your head. And when you heard his response, you wished you had not.

In fact, your association is in favor of reforming the joint and several liability rule and in fact you may be affected more than Dr. Corlin would have led us to believe earlier.

Mr. LEECH. Congressman, I am glad you gave me the opportunity to respond. Yes, we clearly think that the joint and several liability doctrine should be eliminated. There are egregious cases, and you will always have anecdotal incidents, but the deep pocket in situations like that invariably turns out to be the hospital, and we don't think that is an equitable way to solve those problems.

Thank you for that.

Mr. McCRERY. Thank you for clarifying your nod there.

On one quick question to you, Mr. Leech, on the question of national standards.

We have not spoken here today because we are talking about medical malpractice, but a related problem is product liability for medical technology. Is it your opinion that we need a national standard for product liability, generally, and specifically for medical products?

Mr. LEECH. Actually, the AHA's position is that we need to deal specifically with the medical liability, the hands-on issue, as opposed to bringing in the entire equipment manufacturer responsibility. That is really a different issue. We are talking about health care reform, and dragging in product liability, I think, would make even more complex a complex problem.

Mr. McCRERY. Yes, but those of us that sit at this desk are concerned about the budgetary impact of the health care system generally. And in your experience as a practicing attorney, do you see that a national standard for products would be of any assistance

in controlling health care costs due to the purchase of high-tech equipment?

Mr. LEECH. I would like to defer that. I really do not have an opinion on it. I do know that the hospitals are concerned, and they are obligated to report now defective equipment in their institutions, but whether or not it goes to the next level, I just don't have an opinion.

Mr. MCCRERY. OK. Thank you.

Mr. LEVIN. Thank you Mr. McCrery. We lead witnesses all the time. Never a problem.

We should get to the next panel, but because we are going to be having some votes fairly soon. But let me, if I might, just ask a few basic questions so we are clear.

I take it from your testimony all of you favor retention of the fault system in the area of malpractice? Do any of you favor eliminating that system?

Mr. LEECH. On behalf of the AHA I can say that is a basic tenet of our position is—that is, fault in the sense of negligence. There should be a required finding to any damage relief.

Mr. LEVIN. And so that is true of all of you. You would not eliminate that as a basis for handling this entire issue. And the reason for that is because you do think the fault system has helped to improve the quality of care?

Dr. CORLIN. Mr. Levin, I believe there are two reasons. The principal one is that medical treatment is inexact, and there will not always be circumstances where the results per se can be held up against a fixed standard.

If I go into—with my car because it is missing on one cylinder and the auto mechanic fixes it, I have a reasonable expectation that when it comes out it is going to be hitting on all cylinders.

If someone goes in for heart surgery, neurosurgery, any circumstance, we can't be absolutely certain that the nature of the disease process itself precludes a perfect result.

And if we get into a no-fault system, we will be into a circumstance—and I believe the Don Harper Mills study in California in the mid-1970s alluded to that. If you get into what is referred to as potentially compensable events in a no-fault system, we wind up with something that enormously increases the cost and, secondly, should be funded out of the health insurance and not liability insurance.

Mr. LEVIN. So one reason is the inexact nature of medicine.

And is another reason—perhaps a corollary reason—is that the fault system does put pressure on care givers to act appropriately?

Dr. CORLIN. There are many reasons to act appropriately. One is because of what we are supposed to do.

But I think, under any circumstances, if anybody is operating under any system where, if you don't act appropriately, you are going to suffer some negative consequences you will bear that in mind. Most of us drive 55 or less because it is the speed limit. And I——

Mr. LEVIN. So the answer is yes?

Dr. CORLIN. That is one of the reasons. Right.

Mr. LEVIN. So if that is one of the reasons, as we reform it, we have to be careful. I take it this is a reason why you oppose having

the entity which is responsible being an entity larger than the physician because you want the person who gave the care to be accountable.

Dr. CORLIN. I think all care givers should be accountable for the care they give, but I will point out——

Mr. LEVIN. Why do you have trouble answering the question simply?

Dr. CORLIN. I would agree with you not coming up with the major reason for that conclusion.

Mr. LEVIN. What is the major reason?

Dr. CORLIN. The major reason why we are opposed to enterprise liability is, number one, it is an untried system; number two, there is absolutely no indication whatsoever that it will either reduce premiums or reduce defensive medicine. Those are the two things that we are concerned about from an economic standpoint.

Mr. LEVIN. You don't have a substantial concern in terms of the quality of care that the provider should be the one who is accountable?

Dr. CORLIN. I said, yes, I do think that the provider should be accountable for the care they give.

Mr. LEVIN. So that is, at least, one of the reasons why you would not favor the enterprise approach to malpractice?

Dr. CORLIN. That is correct.

Mr. LEVIN. Would you also then agree that as we reshape the malpractice system, with fault as a foundation, we have to be careful in reshaping it, not to remove too much of the pressure on care givers to act in a nonnegligent way. So we can't make changes willy-nilly. I mean that follows, too, doesn't it?

Dr. CORLIN. I think so. I am not sure I followed that last question, though.

Mr. LEVIN. I just think there has been so much polarization in this field. I think for legislators it has often been difficult to separate the basis for everybody's position.

Most of the people who come before us have an economic self-interest. I don't say that is a malicious factor. It is just there.

And several of you, at least one of you—no, several of you may have—your organizations may have an economic self-interest in opposing the enterprise approach.

Dr. CORLIN. May I respond to that, Mr. Levin?

What we are looking for out of tort reform is a system that will reduce the costs, that will increase the percent of the dollar involved that winds up in the injured patient's pocket and that will be effective in lowering premiums and reducing defensive medicine. And nothing in enterprise liability has ever been proven to show that that will achieve any of those goals.

Mr. LEVIN. You left out as one of the goals to maintain a system that sustains accountability by the care giver.

Dr. CORLIN. Enterprise liability goes counter to that.

Mr. LEVIN. OK. Thank you.

Mr. Chairman, we are ready for the next panel unless you have something.

Chairman STARK [presiding]. I want to thank the panelists very much for their contribution, and we look forward to working with you as we ride through this issue during the health reform discussions in the months ahead.

[The following was subsequently received:]

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May 25, 1993

The Honorable Fortney H. Stark
U.S. House of Representatives
Washington, D.C. 20515-6348

Dear Mr. Stark:

Following my statement before your Subcommittee on Health on May 20, 1993, I had an opportunity to speak with the members of the Board of Trustees of the Ohio Hospital Association concerning your hearings. I explained to them that your intent was to explore the issues of administrative costs, the problems of rural and inner-city hospitals, state insurance programs, and state initiatives on healthcare reform, in addition to reviewing the status of medical liability compensation. To a person they were extremely pleased that you and other representatives who are extremely knowledgeable about the healthcare system would seek information concerning critical elements of our present healthcare delivery system so that appropriate reform actions can take place. They urged me to convey to you their wholehearted support for your hearings and they pledged to participate in a full scale reform of the health delivery system to ensure quality healthcare is given to all Americans on a fair and efficient basis.

I attach a white paper which was prepared jointly by two of Ohio's prominent CEOs, Robert Willett and Laurence Harkness. Mr. Harkness is presently Chairman of the Ohio Hospital Association Board, and has been extremely active in numerous healthcare-related organizations and other charities in the Greater Dayton area. Mr. Willett is also a member of the Ohio Hospital Association Board, and has been extremely active in discussing the appropriate elements of overall healthcare reform in the Southwestern Ohio area. I hope that your Subcommittee will include their white paper in your deliberations.

Personally, as a member of the American Hospital Association Board, as a trustee of numerous healthcare organizations for over twenty years, and as a practicing healthcare and antitrust attorney, I wish to congratulate you upon your efforts to delve into the issue of healthcare reform through your Subcommittee. The entire problem is exceedingly complex, but I am convinced that with the dedication and support of all elements of the healthcare delivery system (including hospitals, physicians, long-term care communities, employees, patients, and payors), as well as the Federal and state governments, we can tailor a healthcare delivery system for the United States that will be at the same time compassionate, comprehensive, and affordable. Your efforts are to be applauded.

Sincerely yours,

John D. Leech

JDL/mm
Enclosure

HEALTH CARE REFORM AND THE REALIGNMENT OF INCENTIVES

May 17, 1993

Robert Willett
President & CEO
Kettering Medical Center
Kettering, Ohio

Laurence Harkness
President & CEO
Children's Medical Center
Dayton, Ohio

The first days of President Clinton's term in office are fodder for the analysts and historians. Mrs. Clinton and the Health Care Reform Task Force continue to deliberate while the American people anxiously await the birth of a health care reform package not unlike a nervous parent-to-be.

But waiting is not enough. The immensity and importance of this task demand that every citizen proactively assert his/her concerns in order to influence the development of a reform package which best meets the health care needs of all Americans. Now is the time for each of us to pull together, recognize the need for comprehensive systemic change, tighten our individual and collective belts, and focus on the common objective--quality health care for all Americans at an affordable price.

The most significant barrier to effective and affordable reform is the current misalignment of incentives apparent in the individuals, groups and organizations that all affect the delivery and cost of health care in America. Reform will and must have tremendous impact on this multitude in order to bring current misalignment into alignment and focus on our common objective. We must identify and then consider each of the "players" involved in, or affected by, such changes.

The key question is who are the "players" constituting the system and how must they/we change in order to realign incentives and reform appropriately?

- **Tort reform** is key--defensive medicine is no longer affordable. Let's put reason back

in our health care system for unfortunate outcomes. The "tort insurance crisis" has experienced several phases since the 1960s. Initially, the increase in tort damage awards led to "increased insurance premiums to medical providers, inadequate coverage for certain kinds of risks, and in some instances, termination of coverage" (Depperschmidt, "The Legality of State Limitations on Medical Malpractice Tort Damage Awards"). During the 70s and 80s, increased tort activity resulted in significant insurance rate increases.

- **Fraud and abuse** must be curbed--the culprits must be prosecuted.
- **Physician self-referral** shouldn't be allowed to continue--it undermines the credibility of the health care system.
- **Physician fee** inconsistency and wide fluctuation needs to be brought under control. A capitated system appears to be the best solution, taking into account practice location, risk, stop-loss, excess profit and other factors that will render a fair and consistent reimbursement for physician services. Bringing other factors like tort reform and defensive medicine into alignment will aid in this process.
- **Pharmaceutical pricing** must come under control--profits, yes, a financial bonanza, no!
- **Hospitals** must continue to monitor expenses and take the lead in quality management. They must collaborate with other health care providers and become community resources.
- **Technologic advancements**--important, but America's appetite must be moderated for extending life regardless of quality or cost benefit. While technology can improve efficiency and reduce costs, it can likewise be overused and raise health care costs without improving quality of care. Reform measures need to address the root causes of

overuse, including: uncertainty as to what constitutes appropriate use, increasing specialization within medicine, public demand, competition among hospitals to attract patients, incentives created by reimbursement policies, and defensive medical practices. (Office of Technology Assessment, 100th Congress, "Life-Sustaining Technologies and the Elderly")

- **Duplication of services and equipment**--driven unfortunately by the competitive environment of the past--is passe. Collaboration is the approach of the future.
- **Government regulations**, administrative requirements and just plain insurance paperwork are burdening the system--its too costly. Streamlining is fundamental to reducing costs. Efforts to develop and implement integrated information systems show significant potential for reducing such undue burden, and as a result should be universally supported.
- **Anti-trust regulations** must be relaxed-- for collaboration won't happen without it.
- **Insurance**--community premium rates, portability, insurability--is essential to improve access to millions. According to a 1990 American Hospital Association study, approximately 36 million Americans, or one out of seven, have no health insurance. Of these, approximately 84 percent are either employed, or dependents of someone who is employed. While millions of Americans remain uninsured due to the cost, insurance companies are increasing premiums, co-payments and deductibles, while reducing benefits and posting very healthy earnings. How can Blue Cross & Blue Shield of Ohio justify its $14.8 million earnings in the first quarter of 1993? BC&BS reserves set a new record high at $228.1 million. FHP International, a Fountain Valley, California HMO

chain, announced net income for its third quarter, which ended March 31st, of $14.4 million, a 38% increase from the same period last year.

- **Societal ills** must be controlled. The American people must become more financially accountable for their own health through prevention, cost sharing and the end of self-indulgence. Health care expenses as a direct result of preventable "social ills" such as smoking, obesity, teen pregnancy, sexually transmitted diseases and trauma resultant from not wearing seat belts, to name a few, are inexcusable. According to recent American Hospital Association statistics, the U.S. ranks 21 among developed nations in infant mortality, and 12 in longevity. Micheal Decter, Deputy Minister of Health, Ontario, Canada, states, "What we've discovered is that of the determinants of health, health care is only one of a number, and probably the least important." Education and prevention are key to reform. The system must reward individuals for reducing risk and choosing healthy lifestyles. A systemic emphasis should be placed on long-term behavioral modification.
- **Graduate medical education** needs to directly reflect the physician populations which are needed in today's environment. We cannot afford to continue training medical specialists at the current rate. The value of primary care physicians must be reflected in medical school curriculums, residency positions and health care reform proposals.

Because of the immensity and complexity of these reform/alignment measures, and the vast number of "customers" within the U.S. health care delivery system, there is an obvious need for a philosophical foundation from which change can be constructed. Total quality management (TQM) and its corresponding principles of Continuous Quality Improvement (CQI) appears to

be such a philosophy.

In The Quality Quest: A Briefing for Health Care Professionals, Leebov defines quality as "doing the right things right consistently to ensure:

- **The best possible clinical outcomes for patients**
- **Satisfaction for all of our many customers**
- **Retention of talented staff**
- **Sound financial performance"**

Each of these indicators of quality reflect issues which are central to health care reform efforts. In addition, the principles of CQI have potential to positively impact two areas critical to reform. CQI can both raise "the standards of performance through work processes" (Leebov) and reduce variation in performance.

One criteria essential to successful CQI implementation is **TQM/CQI must begin at the top.** Within any health care organization this effectively means the CEO. However, those involved in redesigning the current system should recognize that they also have a critical responsibility for influencing the universal implementation of CQI. Emphasizing the importance of this common sense philosophy as a central focus of each reform measure will have long-term implications on our health care system. It is time for Americans to recognize the value of principles established by TQM founders W. Edwards Deming and Joseph Juran. It is time to look beyond the "quick fix" of the past.

Today's health care delivery system is an intricate and complicated combination of interacting goods and services. All of the misaligned elements currently found in the system must be addressed to accomplish universal reform. Fixing on one or two will never allow us

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to meet the desired objective.

For this reason, two pivotal components must be simultaneously and emphatically embraced as reform and subsequent legislation is proposed by the health care task force--global alignment of incentives and utilization of the principles of TQM/CQI. For this to become reality, everyone must be educated regarding the current misalignment of incentives and then buy in to the concept of global realignment. It is only through such a comprehensive approach that the intended common objective of reform can be achieved--quality health care for all Americans at an affordable price.

Chairman STARK. Our next panel will consist of witnesses representing the legal profession: Walter Beckham, a member of the Special Committee on Medical Professional Liability, American Bar Association; and Robert E. Meade, vice president of the American Arbitration Association.

Welcome to the committee, gentlemen. Your prepared testimony will appear in the record in its entirety.

And Mr. Beckham, why don't you lead off and enlighten us any way that you are comfortable.

STATEMENT OF WALTER H. BECKHAM, JR., MEMBER, SPECIAL COMMITTEE ON MEDICAL PROFESSIONAL LIABILITY, AMERICAN BAR ASSOCIATION

Mr. BECKHAM. Thank you, Mr. Chairman. I appreciate the opportunity to present the views of the American Bar Association, which is the world's largest professional association, on medical professional liability in the context of proposals to increase access to health care.

As you have mentioned, my name is Walter Beckham. I am a member of the ABA's Special Committee on Medical Professional Liability. Most of my active practice in the profession of the law, which I have practiced over 40 years, has been on the plaintiff's side of personal injury litigation, Mr. Chairman.

Since 1972, the ABA has been on record in support of legislation that would provide for every American to have access to quality health care, regardless of a person's income. In February, 1990, the ABA's House of Delegates reaffirmed its support of such legislation, calling for universal coverage for all through a common public or public/private mechanism through which all contribute.

The American Bar Association is concerned about the ability of Americans, including its own members, to obtain affordable health insurance. Health care at a reasonable cost has been an American expectation and a concept the American Bar Association supports.

Likewise, access to the American legal system has been a fundamental right tracing back to the beginnings of our country.

We understand the concerns being expressed about the issue of medical professional liability. The ABA is deeply committed to having a legal system in America that is effective and just and one that protects the rights of plaintiffs and defendants.

A recent Congressional Budget Office study reported that medical malpractice premiums account for less than 1 percent of the dollars spent annually on the Nation's health care. These premiums cover all the payments made to individuals because of malpractice.

The report also concluded that much of the care that is commonly dubbed defensive medicine would probably still be provided for reasons other than concerns about medical malpractice. Physicians have always sought to provide patients with the best possible medical care at the lowest risk and would continue to do so even without the threat of lawsuits because much of this so-called defensive care helps to reduce the uncertainty of medical diagnosis.

It seems unlikely that physicians would change their practice patterns dramatically in response to medical reforms.

Mr. Chairman, I am not going to continue with the recitation of what we have submitted in our statement. I think it would be helpful to this panel of the Congress to be able to ask me questions, and I am here prepared to answer those questions.

But one thing I would like to make clear before I close this opening statement is that, in our judgment, medical practice reforms as proposed by the American Medical Association have no real relevance to and would have no material effect on the cost of health care in the United States. They only would serve to give the medical profession a special place in our legal system which is not shared by any other profession and at the expense of those people who are injured or killed as a result of medical negligence.

I have prepared a very simple little pie diagram here and what you see there in red is the cost of medical malpractice premiums as compared to the total cost of health care. And you could abolish medical malpractice, Mr. Chairman, and it would not materially affect the cost of health care in the United States.

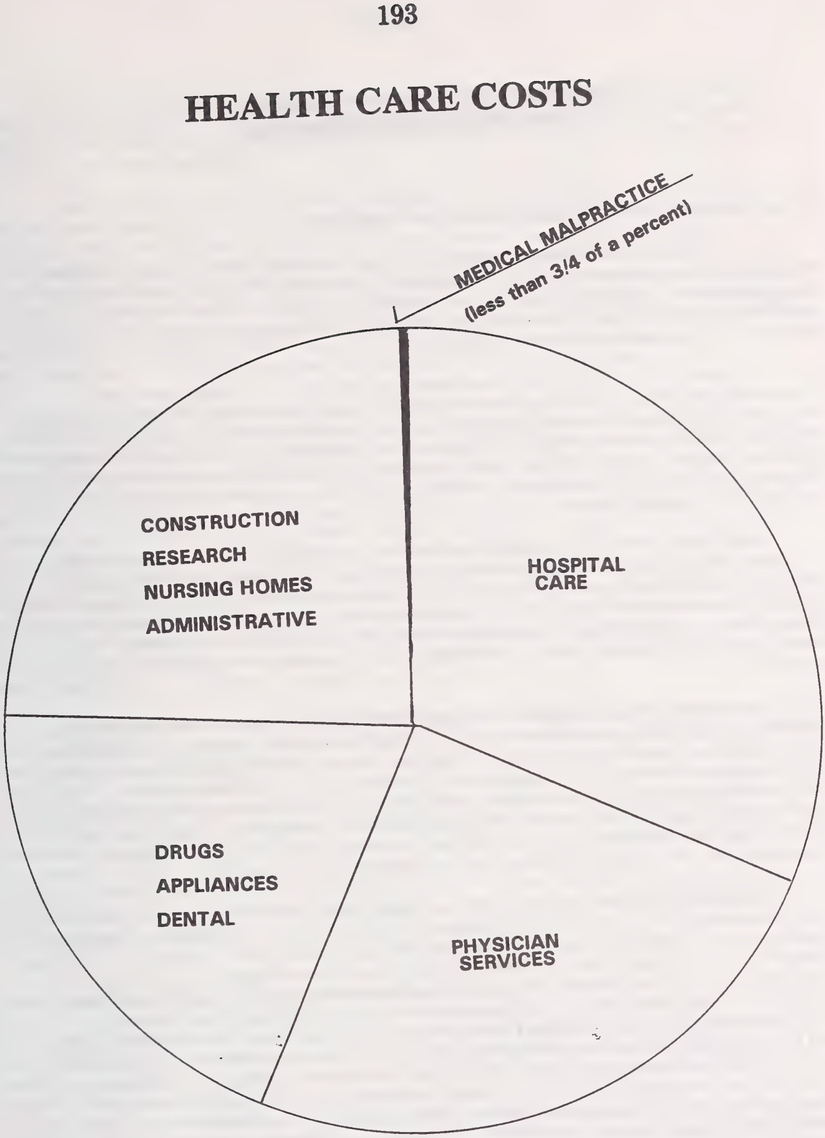
And this means that what we are talking about here should not be presented to the American people as something that is going to materially reduce the cost of health care in the United States because the empirical evidence simply does not support that.

Thank you, Mr. Chairman. I am prepared to answer questions.

Chairman STARK. I am prepared to ask them.

[The chart and statement follow:]

HEALTH CARE COSTS



TESTIMONY OF WALTER H. BECKHAN, JR.
AMERICAN BAR ASSOCIATION

Mr. Chairman and Members of the Committee:

I appreciate the opportunity to present the views of the American Bar Association on medical professional liability in the context of proposals to increase access to health care. I am Walter Beckham, a member of the ABA's Special Committee on Medical Professional Liability.

Since 1972, the ABA has been on record in support of legislation that would provide for every American to have access to quality health care regardless of a person's income. In February 1990, the ABA's House of Delegates reaffirmed its support of such legislation calling for universal coverage for all through a common public or public/private mechanism through which all contribute.

The American Bar Association is concerned about the ability of Americans, including its own members, to obtain affordable health insurance. Health care at a reasonable cost has been an American expectation, and a concept the American Bar Association supports. Likewise, access to the American legal system has been a fundamental right tracing back to the origins of this country.

The ABA understands the concerns being expressed about the issue of medical professional liability and is deeply committed to having a legal system in America that is effective and just, one that protects the rights of plaintiffs and defendants. Two ABA entities worked towards this end by developing recommendations for the ABA's House of Delegates. They are the Special Committee on Medical Professional Liability and the Action Commission to Improve the Tort Liability System.

The ABA Special Committee on Medical Professional Liability was composed of a balanced group of plaintiffs' lawyers, defense lawyers and representatives of academia, and the judiciary. The Committee was chaired by ABA Immediate Past-President Talbot S. D'Alemberte, then Dean of the Florida State University College of Law. The Committee was charged with studying legislative initiatives in the medical malpractice area and developing ABA policy proposals for the Association's policymakers to consider. In February 1986, the ABA House of Delegates adopted a resolution upon recommendation of the Committee. (A copy of that resolution is appended to this statement as Appendix A.) The Committee was then disbanded. However, it was reactivated in August 1991.

Near the end of 1985 the ABA, through its President, appointed an Action Commission to Improve the Tort Liability System. The 14-member Commission was asked to develop specific proposals to improve the tort liability system. The members of the Commission were federal trial and appellate court judges; a state Supreme Court justice; corporate counsel, including those with insurance experience; consumer and civil rights advocates; academicians; and practicing plaintiffs' and defense lawyers.

In February 1987, the ABA House of Delegates considered the Commission's recommendations and adopted the resolution appended to this statement as Appendix B. The ABA takes the position that these proposals to improve the tort system can and should be implemented by the courts and legislatures at the state, and not the federal level.

Our ABA policies reflect the ABA's recognition that the issue is of vital importance not only to the legal profession but to the medical profession, the insurance industry and, most of all, to the public.

The public has the most at stake in this issue. When a person suffers injury as a result of negligence by a provider of health care services, he or she must have the right to seek recovery for the full measure of those damages. We believe that right is severely threatened by those who call for major changes in this country's tort law system, and particularly by those who propose that limits be placed on the amount of damages persons may seek in compensation for their injuries caused by the negligence, or carelessness of health care providers.

We are particularly concerned with proposals to alter the system of medical malpractice to carve out exceptions in the tort law system for one group of potential defendants -- in this case, the medical profession. It is the ABA's belief that the rights of injured persons to recover fully for injuries caused by the wrongful acts of others must be protected. We are concerned that those who seek major changes in the way the tort law system deals with cases of medical malpractice are willing to trade away the rights of all individuals in the hope of easing a perceived burden on some or reducing the overall costs of health care. Since medical malpractice insurance costs make up only a small fraction of the dollars spent on health care in the United States, the changes in the tort laws would have no real impact on costs of health care.

In addressing access to health care proposals, that contain provisions on medical professional liability, three questions need to be asked. First, what is the cost savings that can be achieved? Second, have such provisions, when enacted, lowered health care costs in states which have adopted their essential elements? Third, what are the consequences to the traditional American legal system and to the rights of the injured persons? In other words, does a cost shifting from the medical professional who caused the injuries to the person who was injured or to a governmental agency achieve anything more than an illusory savings?

What is the Cost of the Medical-Legal System?

The American Bar Association does not purport to possess the expertise to analyze all of the reasons for escalating medical costs. We do, however, have the ability to analyze the interrelationship of the legal system and those costs. Moreover, we are able to determine the consequences of proposed legislation upon the American legal system and those seeking compensation for injuries.

The major components that have been cited as contributing to the rising cost of that care are:

* Reliance on modern, sophisticated and expensive treatment.

* Innovative treatment of illnesses, such as heart disease, AIDS and cancer;

* An aging population, which adds to Medicare and Medicaid expenditures;

* High administrative costs of the health care system; and

* The medical-legal system.

Studies concerning the medical-legal system show that its impact on the national expenditures is not only questionable but also insignificant.[1] The Congressional Budget Office stated in 1992 that medical-legal costs, as measured by medical malpractice insurance premiums, account for 0.74 percent of the national health expenditures.[2] I understand that these insurance premiums account for a lower percentage of national health expenditures at this point in time. The other component of cost attributed to the legal system is that of so-called "defensive medicine." Varying figures for the cost of "defensive medicine" have been estimated. However, no one has reliably measured what, if anything, defensive medicine costs.

An October 1992 study of the Congressional Budget Office concluded that health care spending is propelled upward by high-cost technological and medical breakthroughs. The study finds that rising incomes, demographic changes, and medical malpractice costs do not appear to account for much of the increase in the nation's health care bill. The report states that malpractice insurance premiums account for less than one percent of the dollars spent annually on the nation's health care.

The report also concluded that "much of the care that is commonly dubbed 'defensive medicine' would probably still be provided for reasons other than concerns about medical malpractice. Physicians have always sought to provide patients with the best possible medical care at the lowest risks and would continue to do so even without the threat of lawsuits. Because much of this 'defensive care' helps to reduce the uncertainty of medical diagnosis, it seems unlikely that physicians would change their practice patterns dramatically in response to malpractice reform."[3]

To address the subject of "defensive medicine," there must be agreement upon the meaning of the phrase. However, there is no agreement upon the definition.[4] That uncertainty has resulted in the inability to statistically measure the cost.[5] In published studies, "defensive medicine" has included erroneously the cost of the consequence of physicians' financial incentive to direct patients for tests and examinations in facilities in which physicians have a proprietary interest.[6] Some have considered the cost of new technology and advancements in medical knowledge, care and treatment. In that regard, patients expect the use of very modern, sophisticated and expensive technology to refine diagnosis and eliminate uncertainties.

Therefore, to examine the impact of the medical-legal system, the necessary inquiry is to what extent physicians direct medical expenses that are unwarranted for the treatment or diagnosis of patients, and are not motivated by personal financial interests. In other words, an expense is only attributable to the medical-legal system when the sole reason for that expense is concern by the physician about a medical malpractice claim. There has been no study to measure that cost, and there appears to be no basis for assuming that competent and reputable physicians impose such expenses upon their patients without a justifiable medical reason.

To the extent that physicians' concern about liability results in more conscientious medical care, then "defensive medicine" is certainly desirable.[7] When the fear of tort liability deters medical injuries, then health care costs are lowered by avoiding the costs associated with medical injury.[8] Thus, if liability concerns are a deterrent, provisions that relieve physicians of concern regarding negligent practices can actually result in an increase of health care costs.

Because no reliable studies have been done to estimate the cost of so-called defensive medicine, the Office of Technology Assessment has been asked to study the issue and is expected to complete its study before 1994.

Medical Malpractice Litigation

The cost of medical malpractice insurance, in part, reflects the cost of the medical-legal system. In contrast to the increase in health care costs, medical malpractice costs decreased in recent years.[9] The number of medical malpractice claims peaked in 1985, and has continued to decline according to the most current figures available.[10]

Medical-legal costs, as measured by medical malpractice insurance premiums, account for less than three quarters of one percent of the nation's health expenditures. Major pending proposals to change the tort laws would result in a negligible impact on health care costs. A recent study funded by the Texas Medical Association, the Texas Trial Lawyers Association and the Texas Hospital Association reported that its findings indicated that "changing the medical professional liability system will have minimal cost savings impact on the overall health care delivery system in Texas."[11]

A recent study examined the relationship between medical malpractice tort "reform" and health care costs and found there to be "no indication that enacting major tort 'reforms' is positively correlated with lower health care costs." In fact, the study found that "states with the lowest per capita expenditures are more likely to have enacted fewer tort 'reforms' overall than the average."[12]

In comparison to other components of health care costs, administrative costs, for example, are 10 to 24 times the cost of all medical malpractice claims.[13]

What are the Consequences to the Public of Proposals to Cap Noneconomic Damages or Eliminate the Collateral Source Rule in Medical Malpractice Cases?

Proposals of this type are ill-advised. Elimination of the collateral source rule solely favors medical professionals by passing on the cost of the medical injury to another health care provider. Often, an insured person has the benefit of health or disability insurance which pays for a portion of the additional medical costs attributable to the injuries caused by a physician's negligence. Typically, the insurer will assert a lien against its insured's recovery or pursue a subrogation claim. Under proposals to eliminate the collateral source rule, the negligent physician would get a credit for the insurer's payment, and the insurer could not recover from the person who injured its insured. An obvious consequence of the loss of lien and subrogation rights by a health or disability insurer will be an increase in those premiums. Where government proposals provide such insurance, government health care costs would increase. The net result is no reduction in health care costs but a windfall benefit to the defendant medical professional and his or her insurer at the expense of the injured person.

Proposals to limit noneconomic damages deprive individuals of compensation for the consequences of medical malpractice injuries. No one has stated that such injuries are not real or severe. In fact, noneconomic injuries may far exceed the economic damages. These proposals, if enacted, would make seriously injured persons who are the least able to afford it

receive less than full compensation while less seriously injured persons would be fully compensated. This would be grossly unjust.

A bottom line is whether the economic benefits to the public in reducing health care cost is significant enough to warrant depriving other members of the public -- injured persons -- of full and adequate compensation from those responsible for their injuries. With the cost of the entire medical-legal system constituting less than one percent of health care costs, a pertinent inquiry is whether such proposals would have any noticeable impact except upon injured persons.

Such proposals would not eliminate the less than one percent of health care costs attributable to medical professional liability since no one seriously urges that the medical profession should be immune from liability. Rather, such proposals are directed at those injured persons who are ultimately compensated. These victims of medical negligence are the subject of such proposals. Any savings in the cost of health care would be a small fraction of a percent. Thus, even on an economic analysis, such proposals, if implemented, will not have a measurable impact upon the cost of health care. Such proposals, however, would impact severely and dramatically upon the persons who are victims of medical malpractice.

Should alternative dispute resolution be included in a national health access proposal?

The ABA has long supported the use of various methods of alternative dispute resolution (ADR) and was an early leader in advocating for its use. We encourage providing appropriate ADR options in a national health access proposal as an efficient means of expediting medical malpractice claims.

In 1976, the ABA co-sponsored a conference in St. Paul, Minnesota. The conference sought to address two principal topics: "What types of disputes are best resolved by judicial action and what kinds are better assigned to another more appropriate forum?," and "Can the interest of justice be better served with processes less time-consuming and less expensive?" The conference discussions led to the appointment of a "Pound Conference Follow-up Task Force," under the chairmanship of Judge Griffin Bell. The Task Force published a report with numerous recommendations for justice reform in August, 1976.

A principal recommendation of the report is that a variety of innovative dispute resolution techniques be explored: arbitration, mediation, revitalized and expanded small claims courts, and the concept of a "neighborhood justice center."

In 1977, when the ABA established its Standing Committee on Dispute Resolution, that subject was relatively obscure; however, during the past 16 years, the ABA through its Standing Committee and its newly established Section on Dispute Resolution, has chartered the nation's dispute resolution agenda. The Multi-Door Courthouse, school mediation and police dispute resolution programs were unknown concepts until after the ABA's 1976 Conference on Improvements in the Administration of Justice.

Today, the dispute resolution world is dramatically different. Much has happened, in part because of ABA leadership. The extensive work of the ABA is described in a document entitled the ABA Blueprint for Improving the Civil Justice System. Copies of the "Blueprint" are available upon request.

The ABA's House of Delegates has adopted four resolutions relevant to ADR and medical malpractice. The resolutions call for the following:

1. To promote continued use of and experimentation with ADR, both before and after suit is filed, as welcome components of the justice system. (Adopted August 1989.)

2. Consistent with the attached ABA policy (Appendix C), to support the increased use of ADR by federal agencies, which included support for the recently passed Administrative Dispute Resolution Act of 1990. (Adopted August 1988.)

3. To support the use of arbitration for resolution of medical malpractice disputes under circumstances whereby the agreement to arbitrate is entered into only after a dispute has arisen. (Adopted August 1977.)

4. To support the voluntary use of arbitration so long as the parties have full knowledge that once entered into, the arbitration panel's decision is final and binding; and that arbitration panels should consist of one impartial arbitrator in "small" claims cases and three arbitrators - an attorney, a physician, and a layman in larger claims cases. (Adopted August 1976.)

The ABA is concerned about achieving a more expeditious and economical resolution of medical malpractice litigation. Voluntary alternative dispute resolution, for example, has gained acceptance as an alternative to litigation. The ABA recognizes the importance of the development and use of ADR methods other than full judicial trials for resolving legal disputes. ABA policy supports the "continued use of and experimentation with alternative dispute resolution techniques both before and after suit is filed," so long as they assure that every disputant's constitutional and other legal rights and remedies are protected. Of course, such concepts have equal validity in litigation against any defendant, and no special justification exists for being applied only in cases involving medical professionals.

The use of voluntary alternative dispute resolution techniques is consistent with the relevant policy considerations of attracting to an overburdened judicial system the independent and impartial services and expertise upon which that system necessarily depends. Besides relieving court congestion and speeding up the conclusion of cases, these alternative dispute resolution procedures are often less expensive and less stressful than seeing a case through its normal trial path.

Thank you for giving us this opportunity to present our views to you.

ENDNOTES

1 According to the 1992 U.S. Industrial Outlook prepared by the U.S. Department of Commerce, in 1991 national health care outlays accounted for approximately 13 percent of the GNP, totaling $738 billion up about 11 percent from $666 billion in 1990. The medical-legal component in the same period, however, appears to have decreased since health care costs greatly increased during this period and malpractice premiums decreased.

2 Testimony, Robert D. Reischauer, Director, Congressional Budget Office, Statement before the Committee on Ways and Means, U.S. House of Representatives, March 4, 1992.

3 Congressional Budget Office, Economic Implications of Rising Health Care Costs (October 1992) page 27.

4 The American Medical Association has estimated the cost of defensive medicine based upon a survey of physicians who were asked, for example, whether they ordered more tests because of the perceived risk of a medical malpractice claim. The AMA, moreover, recognized other reasons contributed to an affirmative response, stating, "like other defensive measures, all defensive medicine cannot be characterized necessarily as overuse but can reflect necessary improvements in patient care." Statement on behalf of the American Medical Association to the Senate Finance Subcommittee on Medicare and Long Term Care Regarding Medical Liability Reform, October 16, 1991, page 4.

5 The Physician Payment Review Commission (PPRC) has questioned such figures, noting that "Studies that use physicians' estimates of the amount of defensive medicine they practice are not sufficiently reliable to make quantitative estimates." Physician Payment Review Commission 1991 Annual Report to Congress, page 374.

6 Mark N. Cooper, "Physician Self-Dealing for Diagnostic Tests in the 1980s: Defensive Medicine vs. Offensive Profits," Consumer Federation of America, October 3, 1991, reported that the rapid spread of physician ownership of diagnostic testing facilities is a much more likely cause of rising diagnostic costs than fear of malpractice liability.

A January 1991 study by the State of Florida's Health Care Cost Containment Board looked into physician ownership of health care facilities. It found that joint ventures among health care providers resulted in higher health care costs due primarily to the over-utilization of services.

A study of radiation centers in Florida found that doctor-owned centers appeared to result in a substantial increase in use and cost of the services. See Mitchell, Jean M.; Sunshine, Jonathan H.; "Consequences of Physicians' Ownership of Health Care Facilities - Joint Ventures in Radiation Therapy, The New England Journal of Medicine, Vol.327, No.21, Nov. 19, 1992, pages 1497-1501.

Another study examined workers' compensation claims in California and found that self-referral increases the cost of medical care covered by workers' compensation for physical therapy, psychiatric evaluation services and MRI Scans. Swedlow, Alex; Johnson, Gregory; Smithline, Neil; and Milstein, Arnold, "Increased Costs and Rates of Use in the California Workers' Compensation System as a Result of Self-Referral by Physicians," The New England Journal of Medicine, Vol.327, No.21 Nov. 19, 1992, pages 1502-1506.

7 Patricia M. Danzon, "Liability for Medical Malpractice," Journal of Economic Perspectives, Vol.5, No.3, Summer 1991, pages 51-69. Ms. Danzon concludes that liability concerns have brought about some efficient changes in practice.

The Physician Payment Review Commission Annual 1991 Report also discusses other possible causes of inefficient and inappropriate defensive medicine.

* Physicians and hospitals often benefit financially by delivering more care.

* Insurance does not deter physicians from ordering additional tests because insurance provides funding for that which a patient could not otherwise afford.

* So-called defensive medicine practices often have become the standard of care adopted by the medical community, and reflect an advancement in technology or care.

8 Testimony, Robert D. Reischauer, Director, Congressional Budget Office, Statement before the Committee on Ways and Means, U.S. House of Representatives, March 4, 1992, Appendix F, page 32.

9 1989 Profitability Study (By Line By State) 1990 Profitability Study (By Line By State), 1991 Profitability Study, National Association of Insurance Commissioners, 1990, 1991, and 1992.

10 Martin L. Gonzalez "Medical Professional Claims and Premiums 1985-1990," Socioeconomic Characteristics of Medical Practice 1992, page 23.

11 Medical and Hospital Professional Liability," a report prepared for the Texas Health Policy Task Force by Tomm and Associates, July 1992.

12 Andrea Dubin, False Claims: The Relationship Between Medical Malpractice "Reforms" and Health Care Costs, prepared for the Coalition for Consumer Rights, March 1993, at Page 2.

13 See Woolhandler S., Himmelstein D.U., The Deteriorating Administrative Efficiency of the U.S. Health Care System. New England Journal of Medicine, 1991; 324; 1253-1258.

APPENDIX A

RESOLUTION APPROVED BY THE AMERICAN BAR ASSOCIATION HOUSE OF DELEGATES

FEBRUARY 11, 1986

BE IT RESOLVED,

1. The American Bar Association urges appropriate ABA entities, such as the Action Commission to Improve the Tort Liability System and the Commission on Professionalism, to continue to consult, where appropriate, with representatives of the American Medical Association and others in the health care industry, the insurance industry, state and federal governments and appropriate segments of the public with the goal of seeking a broader consensus on how more equitably to compensate persons injured in our society. The problems associated with medical professional liability are common to all areas of tort law and should be evaluated in the context of their broader implications for the tort system as a whole. The Legal and Medical professions should cooperate in seeking common solutions to these problems and should avoid any efforts to polarize the discussion of these problems, which would serve neither the public interest nor the interests of either profession.

2. Consistent with these goals, the American Bar Association adopts the following principles:

A. The regulation of medical professional liability is a matter for state consideration; and federal involvement in that area is inappropriate.

B. There should be rigorous enforcement of professional disciplinary code provisions which proscribe lawyers from filing frivolous suits and defenses; and sanctions should be imposed when those provisions are violated.

C. There should be more effective procedures and increased funding to strengthen medical licensing and disciplinary boards at the state level; and efforts should be increased to establish effective risk management programs in the delivery of health care services.

D. No justification exists for exempting medical malpractice actions from the rules of punitive damages applied in tort litigation to deter gross misconduct.

E. No disclosure of financial worth by a defendant in a tort action should be required unless there is a showing by evidence in the record or proffered by the plaintiff that would provide a legal basis for recovery of punitive damages.

F. Notices of intent to sue, screening panels and affidavits of non-involvement are unnecessary in medical malpractice actions.

G. No justification exists for a special rule governing malicious prosecution actions brought by health care providers against persons who sued them for malpractice.

H. Trial courts should scrutinize carefully the qualifications of persons presented as experts to assure that only those persons are permitted to testify who, by knowledge, skill, experience, training or education, qualify as experts.

I. The collateral source rule should be retained; and third parties who have furnished monetary benefits to plaintiffs should be permitted to seek reimbursement out of the recovery.

J. Contingent fees provide access to the courts; and no justification exists for imposing special restrictions on contingent fees in medical malpractice actions.

K. The use of structured settlements should be encouraged.

L. Collection and study of data on the cost and causes of professional liability claims should be undertaken to evaluate and develop effective loss prevention programs.

APPENDIX B

RESOLUTION APPROVED BY THE AMERICAN BAR ASSOCIATION HOUSE OF DELEGATES*

February 16-17, 1987
(Report No. 123)

Be It Resolved, That the American Bar Association adopts the following recommendations:

A. Insurance

1. The American Bar Association should establish a commission to study and recommend ways to improve the liability insurance system as it affects the tort system.

B. Pain and Suffering Damages

2. There should be no ceilings on pain and suffering damages, but instead trial and appellate courts should make greater use of the power of remittitur or additur with reference to verdicts which are either so excessive or inadequate as to be clearly disproportionate to community expectations by setting aside such verdicts unless the affected parties agree to the modification.

3. One or more tort award commissions should be established, which would be empowered to review tort awards during the preceding year, publish information on trends, and suggest guidelines for future trial court reference.

4. Options should be explored by appropriate ABA entities whether additional guidance can and should be given to the jury on the range of damages to be awarded for pain and suffering in a particular case.

C. Punitive Damages

5. Punitive damages have a place in appropriate cases and therefore should not be abolished. However, the scope of punitive damages should be narrowed through the following measures:

a. Standards of Conduct and Proof

Punitive damages should be limited to cases warranting special sanctions and should not be commonplace. A threshold requirement for the submission of a punitive damages case to the finder of fact should be that the defendant demonstrated a conscious or deliberate disregard with respect to the plaintiff. As a further safeguard, the standard of proof to be applied should be "clear and convincing" evidence as opposed to any lesser standard such as "by a preponderance of the evidence."

*With the possible exception relating to mass torts, the ABA takes the position that these proposals to improve the tort system can and should be implemented by the courts and legislatures at the state and not the federal level.

b. The Process of Decision

(1) Pre-Trial - Appropriate pre-trial procedures should be routinely utilized to eliminate frivolous claims for punitive damages prior to trial, with a savings mechanism available for late discovery of misconduct meeting the standard of liability.

(2) Trial - Evidence of net worth and other evidence relevant only to the question of punitive damages ordinarily should be introduced only after the defendant's liability for compensatory damages and the amount of those damages have been determined.

(3) Post-Trial - As a check against excessive punitive damage awards, verdicts including such awards should be subjected to close scrutiny by the courts. The trial court should order remittitur wherever justified. Excessiveness should be evaluated in light of the degree of reprehensibility of the defendant's acts, the risk undertaken by the plaintiff, the actual injury caused, the net worth of the defendant, whether the defendant has reformed its conduct and the degree of departure from typical ratios (as reflected in the best available empirical data) between compensatory and punitive damages. If necessary to assure such judicial review, appropriate legislation should be enacted. Opinions issued by trial or appellate courts either upholding or modifying an award should specify the factors which were considered and relied upon.

c. Multiple Judgment Torts

While the total amount of any punitive damages awarded should be adequate to accomplish the purposes of punitive damages, appropriate safeguards should be put in force to prevent any defendant from being subjected to punitive damages that are excessive in the aggregate for the same wrongful act.

d. Vicarious Liability

With respect to vicarious liability for punitive damages, the provisions of Section 909 of the Restatement (Second) of Torts (1979) should apply. Legislatures and courts should be sensitive to adopting appropriate safeguards to protect the master or principal from vicarious liability for the unauthorized acts of nonmanagerial servants or agents.

e. To Whom Awards Should Be Paid

In certain punitive damages cases, such as torts involving possible multiple judgments against the same defendant, a court could be authorized to determine what is a reasonable portion of the punitive damages award to compensate the plaintiff and counsel for bringing the action and prosecuting the punitive damage claim, with the balance of the

award to be allocated to public purposes, which could involve methods of dealing with multiple tort claims such as consolidation of claims or forms of class actions. The novelty of such proposals and the absence of any adequately tested programs for implementing require further study before an informed judgment can be made as to whether, or to what extent, such proposals will work in practice. We urge such studies. The concept of public allocation of portions of punitive damage awards in single judgment actions is also worthy of consideration to the extent workable methods of implementation may hereafter be developed.

D. Joint-and-Several Liability

6. The doctrine of joint-and-several liability should be modified to recognize that defendants whose responsibility is substantially disproportionate to liability for the entire loss suffered by the plaintiff are to be held liable for only their equitable share of the plaintiff's noneconomic loss, while remaining liable for the plaintiff's full economic loss. A defendant's responsibility should be regarded as "substantially disproportionate" when it is significantly less than any of the other defendants; for example, when one of two defendants is determined to be less than 25% responsible for the plaintiff's injury.

E. Attorneys' Fees

7. Fee arrangements with each party in tort cases should be set forth in a written agreement that clearly identifies the basis on which the fee is to be calculated. In addition, because many plaintiffs may not be familiar with the various ways that contingency fees may be calculated, there should be a requirement that the contingency fee information form be given to each plaintiff before a contingency fee agreement is signed. The content of the information form should be specified in each jurisdiction and should include at least the maximum fee percentage, if any, in the jurisdiction, the option of using different fee percentages depending on the amount of work the attorney has done in obtaining a recovery, and the option of using fee percentages that decrease as the size of a recovery increases. The form should be written in plain English, and, where appropriate, other languages.

8. Courts should discourage the practice of taking a percentage fee out of the gross amount of any judgment or settlement. Contingent fees should normally be based only on the net amount recovered after litigation disbursements such as filing fees, deposition costs, trial transcripts, travel, expert witness fees, and other expenses necessary to conduct the litigation.

9. Upon complaint of a person who has retained counsel, or who is required to pay counsel fees, the fee arrangement and the fee amount billed may be submitted to the court or other appropriate public body, which should have the authority to disallow, after a hearing, any portion of a fee found to be "plainly excessive" in light of prevailing rates and practices.

F. Secrecy and Coercive Agreements

10. Where information obtained under secrecy agreements (a) indicates risk of hazards to other persons, or (b) reveals evidence relevant to claims based on such hazards, courts should ordinarily permit disclosure of such information, after hearing, to other plaintiffs or to government agencies who agree to be bound by appropriate agreements or court orders to protect the confidentiality of trade secrets and sensitive proprietary information.

11. No protective order should contain any provision that requires an attorney for a plaintiff in a tort action to destroy information or records furnished pursuant to such order, including the attorney's notes and other work product, unless the attorney for a plaintiff refuses to agree to be bound by the order after the case has been concluded. An attorney for plaintiff should only be required to return copies of documents obtained from the defendant on condition that defendant agrees not to destroy any such documents so that they will be available, under appropriate circumstances, to government agencies or to other litigants in future cases.

12. Any provision in a settlement or other agreement that prohibits an attorney from representing any other claimant in a similar action against the defendant should be void and of no effect. An attorney should not be permitted to sign such an agreement or request another attorney to do so.

G. Streamlining the Litigation Process: Frivolous Claims and Unnecessary Delay

13. A "fast track" system should be adopted for the trial of tort cases. In recommending such a system, we endorse a policy of active judicial management of the pre-trial phases of tort litigation. We anticipate a system that sets up a rigorous pre-trial schedule with a series of deadlines intended to ensure that tort cases are ready to be placed on the trial calendar within a specified time after filing and tried promptly thereafter. The courts should enforce a firm policy against continuances.

14. Steps should be taken by the courts of the various states to adopt procedures for the control and limitation of the scope and duration of discovery in tort cases. The courts should consider, among other initiatives:

(a) At an early scheduling conference, limiting the number of interrogatories any party may serve, and establishing the number and time of depositions according to a firm schedule. Additional discovery could be allowed upon a showing of good cause.

(b) When appropriate, sanctioning attorneys and other persons for abuse of discovery procedures.

15. Standards should be adopted substantially similar to those set forth in Rule 11 of the Federal Rules of Civil Procedure as a means of discouraging dilatory motions practice and frivolous claims and defenses.

16. Trial judges should carefully examine, on a case-by-case basis, whether liability and damage issues can or should be tried separately.

17. Nonunanimous jury verdicts should be permitted in tort cases, such as verdicts by five of six or ten of twelve jurors.

18. Use of the various alternative dispute resolution mechanisms should be encouraged by federal and state legislatures, by federal and state courts, and by all parties who are likely to, or do become involved in tort disputes with others.

H. Injury Prevention/Reduction

19. Attention should be paid to the disciplining of all licensed professionals through the following measures:

(a) A commitment to impose discipline, where warranted, and funding of full-time staff for disciplinary authorities. Discipline of lawyers should continue to be the responsibility of the highest judicial authority in each state in order to safeguard the rights of all citizens.

(b) In every case in which a claim of negligence or other wrongful conduct is made against a licensed professional, relating to his or her profession, and a judgment for the plaintiff is entered or a settlement paid to an injured person, the insurance carrier, or in the absence of a carrier, the plaintiff's attorney, should report the fact and the amount of payment to the licensing authority. Any agreement to withhold such information and/or to close the files from the disciplinary authorities should be unenforceable as contrary to public policy.

I. Mass Tort

20. The American Bar Association should establish a commission as soon as feasible, including members with expertise in tort law, insurance, environmental policy, civil procedure, and regulatory design, to undertake a comprehensive study of the mass tort problem with the goal of offering a set of concrete proposals for dealing in a fair and efficient manner with these cases.

J. Concluding Recommendation

21. After publication of the report, the ABA Action Commission to Improve the Tort Liability System should be discharged of its assignment.

RESOLUTION APPROVED BY THE AMERICAN BAR ASSOCIATION HOUSE OF DELEGATES

AUGUST 1988

Be It Resolved, That the American Bar Association supports the increased use of alternative means of dispute resolution by Federal administrative agencies consistent with the following:

A. General

1. Administrative agencies should adopt alternative methods of dispute resolution for resolving a broad range of issues. These techniques include arbitration, factfinding, minitrials, and mediation. The issues for which they may be employed include matters that arise in formal or informal adjudication, in rulemaking, in issuing or revoking permits, and in settling disputes, including litigation brought by or against the government.

2. Congress and the courts should not inhibit agency uses of the ADR techniques by requiring formality where it is inappropriate.

B. Voluntary Arbitration

3. Congress should act to permit executive branch officials to agree to binding arbitration to resolve controversies. This legislation should authorize any executive official who has authority to settle a matter on behalf of the government to agree to arbitration, either prior to the time a dispute may arise or after a controversy has matured, subject to whatever may be the statutory authority of the Comptroller General to determine whether payment of public funds is warranted by applicable law and available appropriations.

4. Congress should authorize agencies to adopt arbitration procedures to resolve matters that would otherwise be decided by the agency pursuant to the Administrative Procedure Act ("APA") or other formal procedures. These procedures should provide that:

   (a) All parties to the dispute must knowingly consent to use the arbitration procedures, either before or after a dispute has arisen.

   (b) The parties have some role in the selection of arbitrators, whether by actual selection, by ranking those on a list of qualified arbitrators, or by striking individuals from such a list.

APPENDIX C

(c) Arbitrators need not be permanent government employees, but may be individuals retained by the parties or the government for the purpose of arbitrating the matter.

(d) Agency review of the arbitral award be pursuant to the standards for vacating awards under the U.S. Arbitration Act, 9 U.S.C. §10, unless the award does not become an agency order or the agency does not have any right of review.

(e) The award includes a brief, informal discussion of its factual and legal basis, but neither formal findings of fact nor conclusions of law.

(f) Any judicial review is pursuant to the limited scope-of-review provisions of the U.S. Arbitration Act, rather than the broader standards of the APA.

(g) The arbitral award is enforced pursuant to the U.S. Arbitration Act but is without precedential effect for any purpose.

5. Factors bearing on agency use of arbitration are:

(a) Arbitration is likely to be appropriate where —

(1) The benefits that are likely to be gained from such a proceeding outweigh the probable delay or costs required by a full trial-type hearing.

(2) The norms which will be used to resolve the issues raised have already been established by statute, precedent, or rule, or the parties explicitly desire the arbitrator to make a decision based on some general standard, such as "justice under the circumstances," without regard to a prevailing norm.

(3) Having a decisionmaker with technical expertise would facilitate the resolution of the matter.

(4) The parties desire privacy, and agency records subject to disclosure under the Freedom of Information Act are not involved.

(b) Arbitration is likely to be inappropriate where —

(1) A definitive or authoritative resolution of the matter is required or desired for its precedential value.

(2) Maintaining established norms or policies is of special importance.

(3) The case significantly affects persons who are not parties to the proceeding.

(4) A full public record of the proceeding is important.

(5) The case involves significant decisions as to government policy.

C. Mandatory Arbitration

6. Arbitration is not in all instances an adequate substitute for a trial-type hearing pursuant to the APA or for civil litigation. Hence, Congress should consider mandatory arbitration only where the advantages of such a proceeding are clearly outweighed by the need to (a) save the time or transaction costs involved or (b) have a technical expert resolve the issues.

7. Mandatory arbitration is likely to be appropriate only where the matters to be resolved —

(a) Are not intended to have precedential effect other than the resolution of the specific dispute, except that the awards may be published or indexed as informal guidance;

(b) May be resolved through reference to an ascertainable norm such as statute, rule or custom;

(c) Involve disputes between private parties; and

(d) Do not involve the establishment or implementation of major new policies or precedents.

8. Where Congress mandates arbitration as the exclusive means to resolve a dispute, it should provide the same procedures as in Paragraph 4. (b) - (g) above, except that judicial review should be pursuant to the Administrative Procedure Act, but with the courts' bearing in mind the purposes to be gained by arbitration.

Chairman STARK. Mr. Meade.

STATEMENT OF ROBERT E. MEADE, VICE PRESIDENT, AMERICAN ARBITRATION ASSOCIATION

Mr. MEADE. Thank you, Mr. Chairman and members of the committee. I appreciate the opportunity and the invitation to be here today and share thoughts and information on the uses of alternative dispute resolution. I regret that I received my invitation too late to prepare a full text of my comments. I have prepared a limited outline and will submit my full comments.

Chairman STARK. Without objection, the record will be open for 5 days, and we will accommodate you, sir.

Mr. MEADE. Thank you very much.

It is interesting to note in reading over the reports that have been delivered here this morning from the American Hospital Association, AMA and ABA about to be delivered by Public Citizen, and in looking at 11 bills that have been proposed by Congress which I read through yesterday, all of them support some use of some form of ADR in addressing how claims are resolved.

What we are looking at here is not actually tort reform but a means of getting the parties to a decision in resolving their claims which is less expensive, more direct, fair as compared to the legal system.

It has been proven through hundreds of thousands of cases administered by my Association, which by the way is a nonprofit educational association which has been doing research in education since 1926 throughout the United States, that—it has been proven that these methods are capable of resolving disputes much more quickly and for the most part in a very fair manner.

I want to also comment on ADR. We have used the expression ADR many, many times. As recently as 5 years ago, ADR meant final binding arbitration. It really means much more than that. There are many, many ways of approaching resolving disputes, including negotiations which is the most oft-used form of dispute resolution and the least expensive. We have a dispute, we negotiate, and it is resolved through mediation, the minitrial and many other forms.

Many of the models—the Michigan model, the Kaiser Permanente—incorporate different forms. We spoke about a voluntary binding. Nonvoluntary binding. So there are many different forms.

So I would suggest as you look at these you look at them carefully. They bring into play different elements. Some have no appealability. I would ask that when you look at the various systems, question them and decide what they are, binding, nonbinding, et cetera.

On to what I would like to describe is really an example. And Mrs. Johnson asked the question this morning about any experiences with self-insured organizations, self-insured hospitals using these methods. And what I would like to describe is an example of one that is now just finishing the pilot phase which has been in existence for 8 months now. It brings into play a lot of elements of what I think should serve as a model ADR program of a medical facility that is being used at this point.

Some years ago, the Duke University Medical Center in North Carolina, which is a totally self-insured organization, embarked on a program to implement a dispute settlement system, not an arbitration system but an overall dispute settlement system, not directed strictly at medical malpractice but at any dispute the facility has with its patients, including a billing dispute, an administrative person mistreating a person and indeed a medical malpractice suit.

They have implemented a three-step program. The information is sent to the patient's home to read and then explain to them when they arrive for treatment. They are asked to sign the agreement when they go to the outpatient clinic. They are informed that they are not required to sign it, and it will have no effect on the treatment they receive. It is a three-step process.

First, the individual tries to associate directly with the medical facility. If the doctor needs to be involved, the doctor will be present and speak to the patient one-to-one to try to resolve the dispute.

Secondly, there is an effort at mediation where a third party helps the parties to try to negotiate. Nonbinding. It is not binding. The medical facility pays 100 percent of the cost of that mediation effort. Our experience has been throughout the insurance area that mediation is 80 to 85 percent successful in resolving claims. It is very quick, very effective, and the parties play a direct role in reaching the outcome.

Finally, there is an arbitration step. The parties are bound to arbitrate once they sign the agreement. They participate in choosing who the arbitrators will be. They are drawn from a national panel including physicians, attorneys, former judges and public members.

There is no attempt in the program to limit damages that the arbitrators can award. The arbitrators can award punitive damages. Under the RICO statute, they could award tripled damages. There is provided a limited discovery provision where they are not limited from engaging in some sort of discovery to prepare for the case.

As I mentioned, the program has been introduced on a pilot basis, and 500 of the patients have been asked to sign as they go for treatment at the hospital. Within the next 60 days the hospital will initiate the program system-wide.

The 800 physicians that practice exclusively through Duke treat over half a million patients a year so this is a program that 12 to 24 months down the road will be worthy of our further consideration.

I think with those brief comments I will conclude my testimony and be available for any questions. Thank you.

Chairman Stark. Thank you.

Mr. Beckham, I did not get a chance to read your prepared testimony, but I was very intrigued with your summation of it.

I am inclined to share your opinion that malpractice reform would benefit the doctors and certainly not the patients. There is no indication that we could have some concomitant lowering of physicians's fees if we eliminated it.

So I am mightily suspicious that the doctors wouldn't much change the ordering of tests that they order now. Either they practice medicine with professional responsibility and according to an oath, or they don't.

It is like you are telling me that there are some lawyers who want to add extra pages to my will for fear my heirs are going to sue them. Either they wrote a good document or they didn't.

I am, however, intrigued with the idea that some type of preliminary dispute resolution in those areas—I don't know whether you were here when I tried my rather amateurish legal definition of what was negligence and what was just an accident—but the case is now—and this may disappear if we have universal health coverage—that if you have to go back and have the job done over, you have to pay again. Unlike when you get your car fixed and the guy doesn't tune it up right, he ought to do it for free. That is not the case in medical care.

To an extent, we do some of this in workman's compensation. You lost a week's work, you get paid your wages. Somebody paid your medical bills, but you still have the right to sue or you could turn down the offer if you think it is unfair.

Would the Bar Association's view be that you could treat what I think are the rights of citizens for recovery and redress and still allow for some clearing out of underbrush of what I would think of as de minimis, a couple of thousand dollar claims that a lot of hospitals get? Or do you think that would interfere with the process of justice by having any kind of preliminary screening or dispute resolution as Mr. Meade as outlined in his testimony?

Mr. BECKHAM. The American Bar Association has been in the forefront of alternate dispute resolution, Mr. Chairman. And we have no objection but would encourage any process or any procedure that is a voluntary procedure where people wish to go into any kind of a dispute resolution mechanism and to have their disputes settled. As a matter of fact, I think it would be very helpful in what you might call small claims.

Some questions have been asked about why older people don't get into the system. I think a lot of them don't get into the system because they have what are considered small claims, and it does not justify the cost and expense. And I think if we had alternate dispute resolution matters where people could go in and represent themselves it would be a good thing if people do it voluntarily.

I am opposed to mandatory alternate dispute resolution because it runs counter to constitutional requirements in many of our States and would be a difficult thing to impose upon the public.

Chairman STARK. Let me ask this—this is a fine point, but if it were mandatory as it is in workman's comp that you first go through the process but then not mandatory that you accept it, are you comfortable with that? Or does that present some problems?

Mr. BECKHAM. Mr. Chairman, we did that in the State of Florida, and we finally abandoned it because we found that it was cost ineffective, taking up a lot of time and was merely a preliminary to go to litigation where people were serious enough about their suits in order to bring them.

Chairman STARK. If they voluntarily elected to go into these alternative resolutions, would they forego the right, based on information that might be developed in that, to sue? Would they have to be able to maintain that right?

Mr. BECKHAM. If they voluntarily agreed to it after the dispute has arisen, the ABA would approve of that.

Chairman STARK. I would be comfortable with that.

Mr. BECKHAM. We would approve of anything that people would agree to as a way to settle disputes. They can agree to go out in the dark woods and put something on a tree if it settles the dispute. They don't have to go into court if they are in agreement.

The courts are available to settle disputes among our citizens that can't be otherwise settled. And if they agree on other methods to settle them voluntarily after the dispute has arisen, then we would encourage alternate dispute resolution.

Chairman STARK. Thank you.

Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

Mr. Beckham, in your testimony on page 5 where you talk about capping noneconomic damages or eliminating the collateral source rule, proposals of this type, you say, are ill-advised. CBO testified that out of all of the studies that they have looked at that, basically, three things seemed to save money. One of them was the cap on rewards. The other one was prohibiting duplicate payments which would be the collateral source rule. And the third was reducing the statute of limitations.

Just to make sure that I understand you, would you also take reducing the statute of limitations and add it to the two that you have outlined as being ill-advised?

Mr. BECKHAM. I would have to see the proposal to reduce the statute of limitations in order to make an educated answer to that.

Mr. THOMAS. OK. I just wondered if you believe—so, you believe two of the three as listed by GAO as clear winners in terms of saving costs to be ill-advised. Do you think that this is a trend? It seems to me, as someone kind of new to this area, that you are going to get more and more decisions to cap awards, more and more prohibitions on duplicate payments so you may be concerned about this ill-advised trend. Is that a fair statement?

Mr. BECKHAM. Could I answer on the collateral source and on the caps on damages? The caps on damages simply require the most grievously injured people to bear the burden of reducing insurance premiums. It is simply a transfer to the most seriously injured people. It doesn't affect the people that are not seriously injured.

Mr. THOMAS. I understand your arguments, but apparently legislators in a number of States are not buying that. Why are they not buying your argument if there are more and more States going to caps on——

Mr. BECKHAM. Let me look at the empirical data. Let's look at the State of California where all of these reforms were put into effect starting in 1974, 1975, and joint several came in 1986. The interesting thing is this has not reduced California's health care costs at all. It has not reduced the rate of increase of California's health care costs at all. If you look at the GAO study——

Mr. THOMAS. Has California repealed either of those?

Mr. BECKHAM. Have they repealed either of what?

Mr. THOMAS. Of the two points that you just made. Has any State that put in a cap repealed it?

Mr. BECKHAM I don't know. I haven't made a study as to whether they have repealed it, but I know that it has not had any effect on the total cost of health care.

If you will look at the figures——

Mr. THOMAS. Once they get it, they are keeping it for other reasons.

Mr. BECKHAM I don't know why they are keeping it unless the medical lobby is so strong that they get them to keep it. I don't know why they are keeping it.

Mr. THOMAS. So the reason States have gone to capping awards is that the medical lobby is so strong that they have run over the trial lawyers and others putting in these ill-advised changes?

Mr. BECKHAM. That is one of the reasons. That is not the sole reason, but it hasn't had the effect—if I could finish my answer, it would be very helpful to me.

Mr. THOMAS. I know what you are going to say: That it hasn't had any effect on the cost.

Mr. BECKHAM. I don't know that you know what I am going so say before I say it.

Mr. THOMAS. I read your testimony. Unlike the Chairman, I have read it.

I have a series of questions that I would like to leave you——

Mr. BECKHAM I have other answers that I would like to give. Am I forbidden from answering——

Mr. THOMAS. Of course you are not forbidden. I assumed you put your best arguments in the testimony that you presented. If you have fallbacks, if the ones that you gave aren't good enough, I would love to see them.

Mr. BECKHAM. It would take me 1 minute to give you my answer, and we have taken 3 minutes arguing.

Mr. THOMAS. I am not arguing. I am wondering why you would classify something that is a popular trend as ill-advised unless it means that lawyers get less money.

Mr. BECKHAM. No, sir, that is not right. You are taking people's rights. You are not reducing the cost of health care.

Mr. THOMAS. If we are not affecting the cost of health care, do you have any information you would like to submit for the record that shows that lawyers are not getting less money?

Mr. BECKHAM. I have no information on the income of lawyers to submit on this record. No, sir. I have none.

Mr. THOMAS. In terms of capping—so we do know—so we do know that in your opinion in your studies it shows that it doesn't save money.

I have a study that has just been given to me, Mr. Chairman, that I would like to put into the record that clearly shows a significant reduction in medical care service costs once MICRA was put into effect. Clearly, there are a number of provisions that are associated with it, but one of the fundamental ones is, I believe, capping awards. I am anxious to find out what happens in those States precapping versus postcapping in terms of attorneys' settlement costs and how much they actually make.

Here is another chart that I would like to put into the record, which apparently shows that on the basis of fees—oh, that is interesting. This shows in 1975 the fees were at 3.7 percent. In 1982,

they had dropped to 2.9. Once they were repealed by 1985 they went up to 5.4 percent. That is as good a case study as I have seen in terms of what happens on settlements.

So perhaps we would need to share the statistics that you have that indicate that there were no changes at all versus the information that I have and then we can both pursue together a profile of gains or losses of income to lawyers of States that are capped or not capped.

I thank the gentleman for his testimony.

Mr. BECKHAM. If you would give me the opportunity to answer the question, I would be happy to do so.

If you would look at the computations on per capita health care costs using the 1982 HCFA data and 1990 Lewin ICF estimates that are used by the GAO in its February 1992 report entitled "Health Care Spending—Nonpolicy Factors Account for Most State Differences," you will notice in 1982 when California was number two in health costs, that in 1990, California was number two in health costs.

And you will also notice that all of the States are listed there and almost without exception their health care costs have simply increased to be approximately double what they were in the earlier period, irrespective of the tort reforms that they have or have not enacted in those States. And, therefore, these tort reforms have penalized the public by taking away their rights. They have not materially affected the costs of health care in the States where they have been enacted as opposed to the cost of health care in the States where they have not been enacted, and that is the record.

[The following was subsequently received:]

HEALTH CARE COSTS and TORT "REFORM"

Attached is a chart showing the percentage of increase from 1982 to 1990 in personal health care spending per capita, by state. In its February 1992 report entitled "Health Care Spending - Nonpolicy Factors Account for Most State Differences," the General Accounting Office utilized 1982 data compiled by the Health Care Financing Administration (HCFA) and 1990 estimates from Lewin/ICF. This 1982 and 1990 data was used to develop the attached chart.

<u>Health care costs approximately doubled from 1982 to 1990 regardless of whether a state had enacted tort "reforms" and regardless of the type of "reforms" enacted</u>, as is demonstrated by the attached chart.

The attached chart was developed by the American Bar Association Special Committee on Medical Professional Liability and the ABA Governmental Affairs Office. May 1993.

Percentage of Increase from 1982 to 1990 in Personal Health Care Costs Per Capita, State by State

1982 RANKING/STATE*		1982 HCFA data*	1990 LEWIN/ICF Estimates*	% of INCREASE**
1	Massachusetts	$1,508	$3,031	101
2	California	1,451	2,894	99
3	New York	1,417	2,818	99
4	Nevada	1,380	2,757	100
5	Rhode Island	1,351	2,707	100
6	Connecticut	1,348	2,699	100
7	North Dakota	1,325	2,661	101
8	Illinois	1,308	2,619	100
9	Missouri	1,285	2,568	100
10	Michigan	1,281	2,569	101
11	Pennsylvania	1,273	2,536	99
12	Kansas	1,271	2,548	100
13	Ohio	1,247	2,493	100
14	Maryland	1,232	2,436	98
15	Minnesota	1,229	2,480	102
16	Hawaii	1,228	2,469	101
17	Florida	1,228	2,427	98

1982 RANKING/STATE*		1982 HCFA data*	1990 LEWIN/ICF Estimates*	% of INCREASE**
18	Wisconsin	1,219	2,449	101
19	Nebraska	1,216	2,452	102
20	Colorado	1,209	2,415	100
21	Alaska	1,187	2,367	99
22	Iowa	1,176	2,351	100
23	Washington	1,165	2,311	98
24	Oregon	1,165	2,312	98
25	South Dakota	1,154	2,322	101
26	Delaware	1,153	2,268	97
27	Tennessee	1,144	2,262	98
28	New Jersey	1,115	2,224	99
29	Arizona	1,112	2,211	99
30	Texas	1,110	2,192	97
31	Louisiana	1,106	2,185	98
32	Indiana	1,101	2,201	100
33	Maine	1,091	2,175	99
34	Oklahoma	1,086	2,139	97
35	West Virginia	1,057	2,088	98

1982 RANKING/STATE*		1982 HCFA data*	1990 LEWIN/ICF Estimates*	% of INCREASE**
36	Virginia	1,054	2,076	97
37	Georgia	1,048	2,072	98
38	Montana	1,036	2,059	99
39	Alabama	1,033	2,286	121
40	Arkansas	994	1,944	96
41	New Hampshire	986	1,981	101
42	Vermont	978	1,956	100
43	Kentucky	957	1,875	96
44	North Carolina	931	1,833	97
45	New Mexico	904	1,792	98
46	Mississippi	897	1,751	95
47	Utah	896	1,784	99
48	Wyoming	873	1,756	101
49	Idaho	868	1,726	99
50	South Carolina	857	1,689	97
	U.S. Average	1,220	2,425	99

* *This data was obtained from a February 1992 GAO report entitled "Health Care Spending - Nonpolicy Factors Account for Most State Differences." Note that the Lewin/ICF estimates are not directly comparable with the HCFA data because the Lewin/ICF estimates also include administrative costs for private insurance which are excluded from HCFA's data on personal health care expenditures. GAO reported that it conducted its review "in accordance with generally accepted government auditing standards." HCFA estimates that 1990 U.S. personal health expenditures per capita averaged $2,255.*

** *Rounded off to the nearest whole number.*

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Mr. THOMAS. And we will submit additional information, Mr. Chairman, to indicate where costs have come from and where they have gone in the States that are capped.

Thank the gentleman for his testimony.

Chairman STARK. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman.

Mr. Beckham, I want to ask you a question, but before I do I just want to agree with you that in my opinion there is no doubt that with capping noneconomic damages you are limiting the amount that the most egregiously harmed people can receive in a lawsuit. There is no question about that. You are exactly right.

However, what we have to consider is not just the rights or privileges of that universe of people, which is relatively small, but the interest of the public at large. And what we are trying to achieve is some way to get the costs of the medical system under control.

Because it is, frankly, out of control. Those statistics that you just cited, as Mr. Thomas alluded to, are not entirely due to medical malpractice costs. There are a whole number of things that contribute to the increase in health care costs, and we are trying very hard get a handle on all of those reasons. But certainly medical malpractice, according to most experts, is at least a contributing factor.

And I am familiar with your 1 percent graph there, and that is very nice. I can barely see the red, and I am sure that is how you wanted it to appear.

However, you kind of slid over lightly the matter of defensive costs, and you don't offer any authoritative studies to show that defensive costs are not a problem. And, in fact, we have several studies that show that defensive costs do contribute some say mightily to the increase in health care costs. So, understand, we are aware that we are talking about limiting the rights of people, as you would put it, those most grievously harmed. And that is not something that any of us would like to do, but we have a lot of tough decisions that we have to make when it comes to trying to provide for the country at large in their best interest. So I agree with you.

Let me talk about the inefficiency of the system at large. Data cited by the AMA, RAND Institute and others suggest that the medical liability system returns less than half of the premium dollar in compensation to injured patients, the rest going to administrative costs of running the system. These administrative costs are much higher than those in the auto insurance, life insurance or even the health insurance systems and even higher than in the worker's compensation system.

How would you propose that we reform the system to reduce these administrative costs?

Mr. BECKHAM. I think that one of the reforms that would be helpful would be to have a small claims court where people could go in—or a small claims arbitration system or whatever—where people could go in and present their grievances, not in a formal courtroom setting, if they chose to do so. I think that would take out of the system a number of small matters, and it would help people who are not in the system now because they don't wish to partake in a long, drawnout, expensive process.

I think that risk management is cutting down the number of incidents and is going to help a great deal. And I think the more financial incentive the medical profession has to go with risk management, such as doctors owning the hospitals or owning the medical malpractice insurance companies, the more likely that effective risk management is going to happen.

I think that, in addition the practice guidelines like in Maine are going to be helpful because the medical profession sets its own standard of care, as you know, sir, in medical malpractice. It is what a reasonably prudent physician in those circumstances would do. So that if they have up front stated what the standard is and the doctor can show that he has or has not followed that standard, I think that puts it a long way ahead and might do a great deal to help cut down on the expense of expert and other types of testimony and might weed out a great many other cases that might come up.

Mr. McCRERY. Would you allow the defense to use that practice guideline as a standard of defense?

Mr. BECKHAM. I would allow it into evidence. I don't think it should be a complete bar, but I would allow into evidence the fact that the doctor he had complied with it and that it was a standard set by his peers in the medical profession for the procedure that he was doing.

Mr. McCRERY. Thank you, Mr. Beckham.

Mr. Chairman, I have other questions but I will defer.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Mr. Beckham, would you support the guidelines being a rebuttable defense?

Mr. BECKHAM. I didn't understand.

Mrs. JOHNSON. Would you support the guideline's use in court as being a rebuttable presumption?

Mr. BECKHAM. I would support them as being admissible in evidence. I don't think it should be a rebuttable presumption. A presumption merely has to do with going forward with the evidence. It is not a changing of the burden of proof. And I think if you allow it to be put in evidence it would have the same force and effect. I don't think a rebuttable presumption would help.

Mrs. JOHNSON. Do you believe that the movement in the Nation toward outcomes research and toward guidelines, using outcomes research to put pressure on physicians' practice within the light of that knowledge, which is certainly the direction we are moving in government oversight and in priority sector oversight, do you think that that in any way changes the responsibility of the Government to reform the malpractice system?

Mr. BECKHAM. I think that the responsibility of the government to reform the malpractice system is a responsibility that should be exercised at the State level where the malpractice system is implemented.

Mrs. JOHNSON. If you are a lawyer and the government is saying to you, look, in this kind of case all of your colleagues are treating it this way, and we don't think that we should be taking this case to court because none of your colleagues are, they are settling it. And if there were penalties on you for taking cases to court that your colleagues were settling and then the law comes along and

says and the law doesn't give you any protection in those circumstances——

I got this slightly turned around. But if as a lawyer there is a certain practice that you have in handling a case that is unlike your colleagues and the government puts pressure on you not to handle the case that way but to handle it another way that perhaps you don't feel is as good, then how would you respond to that? I mean, would you insist on your right to handle it your way or would you say if you are not going to let me handle it the way that I think is very best, then, by God, you better give me some protection against someone who might come after me who says you owe me money because you didn't handle it this way.

Mr. BECKHAM. In the law, of course, you get into constitutional provisions and constitutional protections as to what a lawyer may or may not do in the furthering of his client's cause. And I think that is a little bit different than some of the other professions.

But I would say this. We do have certain things in the law that are mandated by the legislature. We have to follow those things once they are mandated.

Mrs. JOHNSON. Recognizing——

Mr. BECKHAM. I think that the more they are mandated, the less effective they are, because they don't foresee all of the things that are going to happen.

Mrs. JOHNSON. I understand that, and that is exactly my point. As society presses on individual physicians to handle extraordinarily complex situations that are intellectually complex but also complex legally, then how far does that societal right to press on a physician an individual decision in regard to his patient unless the society also says to that physician if you practice the way we want you to—unless, of course, there is good reason not to, very, very clear and convincing evidence not to—then we are going to expose you to suits.

It seems to me that you were not really taking seriously the different situations that individual practitioners are going to find themselves in in terms of liability as we as a society begin to say the norm is the standard. And anything beyond the norm, beyond the outcomes research, beyond the practice guidelines, you are going to have to base a higher burden of proof to get paid.

You are not going to have to face a higher burden of proof in the courts to say why you didn't do it. So it is a contradictory message we are sending to practitioners out there, unless we align legal policies with health policies as the health policies change.

I don't want to take any more time on that because it is a big issue, but I really think your approach doesn't in any way account for the fact that standards of malpractice are changing and they are changing rapidly and radically and may no longer be in harmony with what the individual practitioner thinks is right though he can't prove that it is necessary to do anything else.

I just lay that aside because I don't think anything that you have said indicates that you are willing to wrestle with that.

Mr. BECKHAM. I assume you don't want me to respond.

Mrs. JOHNSON. I don't. Because I understand what you would say, and I just don't have time in this hearing.

But I want to ask you two things that are very important. What is your reaction to the overwhelming evidence of the number of frivolous suits that are brought if you don't want us to change the law in any very significant way? How would you recommend, then, that we disincentivize lawyers from bringing frivolous suits?

Mr. BECKHAM. Well, I think that many States have rules—similar to rule 11 in the Federal courts. And when you sign a pleading you are signing it stating that you think there is a reasonable basis for a cause of action, and I think lawyers can be disciplined about that.

But I would disagree with you that frivolous suits are out of control because the number of medical malpractice cases peaked in 1985 and has continued to decline according to the most current figures available since that time. So the medical malpractice cases are decreasing, not increasing in number in our society.

Mrs. JOHNSON. That may be true that they are decreasing, but I think studies like the Harvard study and the experience of big insurers indicate that there are far more frivolous suits in the area of medical malpractice. And the reason is clear. You have an absolute, assured source of payment at least on settlement because settlement is cheaper than litigation.

Mr. BECKHAM. Frivolous suits depend on how you define frivolous suits. Some say that any suit that isn't won is a frivolous suit. That is not one in my estimation. And I don't think the doctors or their insurers are any more sure of payment than any other group that have insurance, such as large corporations.

So I don't think there is anything that is so peculiar to the medical profession that makes it have more litigation than any other profession.

Mrs. JOHNSON. I think if you look at the history of some of the insurers that went from settling claims to trying claims you will see what the problem of frivolous suits really is a problem and one of the ways in which it can be attacked. But the legal profession ought to be willing to come forward with some ways that they can deal with what is a clear and documented problem.

Let me go on to another problem. America is the only country that allows people to sue on the basis of contingency payment. And that has been one of the things that has driven medical malpractice suits. Would you be willing for us to not allow contingency suing in this area?

Mr. BECKHAM. Well, this is the process. You know if you close the door to the courthouse you are going to save all of these things. If you don't allow people to litigate, you are going to eliminate malpractice, and you save it all. If you take additional steps to cut people off from their rights, you are going to reduce exposure and premiums and are also taking away from our people the basic rights that they have from the founding of our democracy.

To say that you are going to abolish contingency fees, when this is the only way that many people can get a chance for redress, will make it so that you deny those people the opportunity to have a chance to be heard.

Mrs. JOHNSON. I certainly have been one who has supported subsidies to make legal aid available to everyone, but contingency fees——

Mr. BECKHAM. Have you ever had a legal aid lawyer represent you as opposed to a good personal plaintiff lawyer, ma'am?

Mrs. JOHNSON. Many of them are very, very conscientious.

Mr. BECKHAM. I am not talking about that. I am talking about their ability to handle medical malpractice cases in which they have limited experience and which require large amounts of time and expense to successfully litigate.

Mrs. JOHNSON. I want to ask you one further question.

In the mandatory situation in Florida, where they require mandatory dispute resolution before going to court, did they also have a provision that if you went to court and lost you had to pay all the court costs?

Mr. BECKHAM. No, we did not.

Mrs. JOHNSON. So there was absolutely no incentive to be satisfied with the alternate dispute resolution process and to put your all into that process and rely on it for justice, isn't that correct?

Mr. BECKHAM. I think that is correct, and the reason is that people have a right to go to court if they desire to do so. And I think the more penalties you put on people if they go to court, the more you deny justice to people.

Mrs. JOHNSON. Of course. I would ask Mr. Meade, is there any work that has been done on that kind of a solution? Coupling a dispute resolution system with a slight disincentive of going to court that would be involved in paying the other guy's court costs if you lost?

Mr. MEADE. There are such systems. I can't point to any specific systems at this point that allow that if you go through an arbitration and then choose to go on to a trial de novo or whatever and you do not make out substantially better in a subsequent forum, you pay the attorneys' fees on the other side.

Mrs. JOHNSON. Could you get back to us on that, please.

Mr. MEADE. Yes.

Mrs. JOHNSON. Let's look at the experience of those systems. I think that is a necessary incentive to make the mediation system serious.

Mr. MEADE. Also, the RAND Institute has done at least one study, if not more, on the court systems and the results of those type of systems that I think is available. I could certainly make a copy.

Mrs. JOHNSON. Are there other studies, Mr. Meade, that we should be aware of as we look at the potential for ADR systems to help us in this area?

One of the things I should mention is one of the reasons I am very interested in the ADR system is because there are so many people now who have no access to justice at all. In fact, one can make the case that the great majority of Americans who are the victims of malpractice or the victims of negligence at lower levels have absolutely no access to even discussing the matter to see if they have a case.

Mr. MEADE. It is unfortunate that most of the information with respect to the advantages of ADR and the cost savings, et cetera, are anecdotal. The RAND Institute has been trying for 3 years now to do a really scientific comparative study as a result of going to

litigation, as compared to going to private arbitration. It is very difficult because ofttimes you are comparing apples and oranges.

Some of the insurers have studied their results in submitting 3,000 cases to arbitration, to cases that might have gone to litigation, and they have come up with some studies. There is really no hard data.

Mrs. JOHNSON. But the individual insurance company where they have tried to have comparable groups, there are statistics in the alternate dispute resolution area that are far better than in the litigation area.

Mr. MEADE. They show, for example, there was a Maryland Casualty study that showed comparing several thousand cases, at least the transactional costs for the cases in the $30,000 to $40,000 range, which are relatively small, they saved about $1,800 to $2,000 per case. Transactional costs and the results in terms of what they paid out is about what they felt they should have paid out had the matter gone to court. And I have a copy of that I can provide.

Mrs. JOHNSON. Thank you——

Chairman STARK. Mr. McCrery, do you wish to inquire?

Mr. MCCRERY. Yes.

Mrs. JOHNSON. Mr. Chairman, if you would let me finish my sentence, I was just going to say thank you very much for your testimony.

Mr. MCCRERY. Thank you, Mr. Chairman.

Actually, Mrs. Johnson did ask some of the questions that I had intended to ask. While I have Mr. Beckham here, I would like to inquire if you happen to know if there are jurisdictions around the country that have not adopted a system of comparable fault where the trier of fact or the court assigns specific proportions of the liability to defendants, in other words, percentages of fault?

Are there jurisdictions that still just say you are at fault, you are at fault, you are at fault, and do not assign a percentage of fault?

Mr. BECKHAM. I have not made a study of that, but it is my understanding that there are still jurisdictions that have not adopted comparative fault in negligence cases, yes, sir.

Mr. MCCRERY. And the question of joint and several liability, then, can you see—I mean you have talked a lot about denying justice to defendants and I agree with you that we are talking about doing that to some extent, but can you also see that in the case of multiple defendants where one is found at fault with no percentage of fault applied and his fault is minimal, and the other two or other three or other multiple defendants don't have any money to pay the judgment, it is not really fair or just to make that person pay, either, is it?

Mr. BECKHAM. The American Bar Association has a position on this. My own personal feelings are contrary to the ABA position.

The ABA position is that it favors joint and several liability abolition on noneconomic damages and that they be proportioned according to faults in cases where a defendant's responsibility is substantially disproportionate to liability for the entire loss suffered by the plaintiff. It favors retaining joint and several liability on economic damages.

Mr. McCRERY. Thank you for clarifying that, and I apologize for using the wrong term. I should have said comparative, not comparable.

So the ABA position is that noneconomic damages ought to be paid by defendants according to their share of responsibility as determined by the trier of fact?

Mr. BECKHAM. That is their position, yes, sir.

Mr. McCRERY. And economic damages still would be subject to the joint and several rule.

Mr. BECKHAM. Yes, sir.

Mr. McCRERY. I happen to think, Mr. Chairman, that the ABA has infinite wisdom on that and I agree very much with their opinion.

I am sorry, Mr. Beckham.

Mr. BECKHAM. That is all right. I wish I had time to tell you why, but I don't.

Mr. McCRERY. I can imagine. But I do think that the ABA has struck a good middle ground there that I think has the effect of making the person—making the injured party whole with respect to his economic damages and then, of course, being fair to all defendants for noneconomic damages.

Just one more question. If we are talking about reducing administrative costs of the system, and we are trying to ferret out those inefficiencies in the system and we are even trying to get to the matter of frivolous suits—and I agree with you that there are not multitudes of frivolous suits but there are some, and I hope you would admit there are some frivolous suits brought in this country.

It seems to me if we could arrive at some alternative dispute resolution process, perhaps along the lines suggested by the ABA, three arbitrators, an attorney, a physician, a layman in those cases, and tie to that process some greater risk for the plaintiff and his attorney in going past that alternative dispute resolution stage into the courts, I agree with you, I don't think we should bar entrance into the court system. But if we could just increase the risk for that plaintiff and the attorney of going into the court system, why would you oppose that?

Let me give you an example. If you decide that the alternative dispute resolution did not come up with a fair judgment and you want to go to court, that is fine, but if you do and your judgment is less than that offered by the alternative dispute resolution process, then you would have to pay the costs of the defendant and maybe attorneys fees of the defendant. What is wrong with that?

Mr. BECKHAM. Mr. McCrery, you have a point, of course, that has been tried in other cases. I am suggesting that there is no reason to carve out the medical professional liability system from the rest of the law. It is not justified based upon what we are talking about.

Now, in many States, they have a procedure that if an offer of settlement is made in a case by a defendant and a plaintiff refuses it, then there are certain consequences that go with that if the plaintiff doesn't get out of the case at least a certain amount more than the offer of settlement.

Now, that is the type of thing that I think you are referring to, only you would say it would go to alternative dispute resolution. I see no reason why that should be different for medical malpractice

cases. If you are going to do that, it should be a part of our legal system. It should not be just for medical malpractice cases. There is no reason to single them out.

Mr. McCRERY. Let's say we would apply it to all cases, never mind the fact that medical malpractice might be more technically challenging for juries and all that would lend itself to alternative dispute resolution. But leaving all that aside, let's apply it to the whole legal system, what is wrong with that if we are trying to cut down on the inefficiency of system?

Mr. BECKHAM. I say there is precedence for what you are talking about. I personally feel that anything that stands in the way or penalizes people from their right to go to court and try their cases is not a wise step in the administration of justice. I realize there are other people who don't agree with that and some of the things that we are talking about are evidence of that.

Mr. McCRERY. And I understand and appreciate your argument but you are not denying that we might exact some savings from the system by going to that type of arrangement?

Mr. BECKHAM. Yes, sir. The more you cut down people's rights to go to court, the more you cap their damages, the more you cut them off by statute of limitations, the more money you save, and if you don't allow any of it, you save it all.

Mr. McCRERY. Thank you, Mr. Beckham.

Mr. Chairman, thank you.

Chairman STARK. Mr. Beckham, you touched on that. Who saves the money if we cut down on the statute of limitations or these other things. Where does that savings in medical malpractice go?

Mr. BECKHAM. Mr. Chairman, the only thing I can say is from the empirical evidence, it is being absorbed by the medical profession or the hospitals or whomever. It is not being reflected in the costs as shown by the figures of the costs of health care in the States in which these things have been done. And I have never heard anyone or any study say that defensive medicine is less in States that have adopted these reforms than in States that have not adopted these reforms.

Chairman STARK. Let me suggest to you, sir, for a little basic research, if you just wanted to count the number of MRI machines per capita, you would find that there is no place in the world that exceeds Los Angeles County or Orange County, and where we have had this oft-proclaimed reform, it didn't cut down the number of defensive pieces of equipment. They may not use them all.

I must say, just to make sure that you don't speak with forked tongue, because I am inclined to agree with you about contingent fees. But recently, I recall in the press, in a tobacco case, the court forced the attorney to continue with a case against a tobacco company. I think the attorney was feeling that he had spent an awful lot of his money prosecuting this case and wanted to drop it, but the court said, If you take it on a contingent fee, you must go the distance.

Did the ABA support the court's position in that case, if that is one you are familiar with?

Mr. BECKHAM. I am not familiar with the case.

Chairman STARK. Would your standards of ethics say—the issue was, this was the decedents of somebody who died; they were try-

ing to establish that smoking caused the death. The case had gone on for maybe 20 years and the lawyers wanted to drop out. The court said, No, stay on.

Mr. BECKHAM. I think a lawyer has an obligation in any case that he takes to continue with it until the end of it unless the court allows him to leave it. This court quite rightfully, from what you said, required him to stay.

I might say this on contingent fees, it is interesting to me that the clients don't protest contingent fees. They see how hard the lawyers work. They know how hard medical malpractice cases are. They know of the conspiracy of silence. And they know that only about 25 percent of medical malpractice cases result in any recovery, and there are not any clients protesting. The only people who protest contingent fees are their adversaries. And that has always been a very interesting thing to me. And when they want to cut down on lawyers' fees, I think it would be very helpful to remember that 34 percent of each dollar goes to the defense costs, including defense attorneys fees.

I have never heard anybody say they should cut defense lawyers fees in order to save money in the system. The medical profession wants the best lawyers to defend them, but they want to cut down on the caliber of the lawyers who represent the other side by reducing fees.

Chairman STARK. I gather these things are regulated by State. Is it against the law in Florida to have fee splitting or referral fees for a lawyer?

Mr. BECKHAM. It is not against the law as between lawyers. It is against the law as to anyone other than members of the legal profession.

Chairman STARK. And?

Mr. BECKHAM. And the division of fee has to be based in Florida on the division of the work and the responsibility in the case.

Chairman STARK. So would-be runners or other type of things would be a crime or just unethical.

Mr. BECKHAM. It would be unethical conduct for which a lawyer could and should be disciplined.

Chairman STARK. I guess the other issue, and it is conceivable this would cut into your earnings some, but it occurs to me that you could for the good of the social order and justice do away with or limit the tort liability. What kind of precedent would there be for then replacing that with criminal liability?

I mean, I just have a hunch that the idea of a few months' vacation or years' vacation at government expense often can have a meritorious effect on people's behavior as much as the threat of being sued. I understand a plaintiff's attorney wouldn't like that very much. Criminal defense attorneys probably think it is a great idea.

Mr. BECKHAM. I think the difference, Mr. Chairman, is in the degree of fault. I don't think in our country we have ever felt that simply failing to observe the standard of care of a reasonably prudent person or a reasonably prudent physician in the same or similar circumstances rise to the level that it should be treated as a crime.

I think the criminal courts are filled with people who deliberately or with malice have done acts that are against the law, and I think there is a difference. I don't think that anyone should be criminally prosecuted or incarcerated for a negligent act. Gross negligence, reckless conduct, or willful and wanton misconduct comes closer to criminal conduct and we punish those actions in the civil system by punitive damages.

Chairman STARK. OK. I appreciate the candor of your testimony and your judicious approach to this issue and I appreciate the testimony of Mr. Meade which you have contributed.

Are there any further questions?

Thank you very much.

We will call the final panel consisting of Ms. Pamela Gilbert, Public Citizen's Congress Watch, and Dr. Robert J. Rubin, Lewin-VHI, Inc.

Dr. Rubin has indicated that he has a departure time of 2 o'clock and I am going to ask Ms. Gilbert if she would mind if Dr. Rubin preceded her. The Chair would intend to—actually, I think the Chair ought to recess for just 5 minutes, and I will run and vote and get back as quickly as I can, and we will then be able to proceed.

[Recess.]

Chairman STARK. The Chair apologizes.

Is Dr. Rubin still with us?

Dr. RUBIN. Yes.

Chairman STARK. Do you want to make a few comments and submit your testimony. I understand you do have to run on.

Dr. RUBIN. During the recess I took the opportunity, since it was clear I wasn't going to be able to leave by 2, I took the opportunity to change that. So I would be happy to stay and answer whatever questions the committee has.

Chairman STARK. Then we will hear from Ms. Gilbert, or would you still like to move ahead.

Ms. GILBERT. Go ahead.

STATEMENT OF ROBERT J. RUBIN, M.D., PRESIDENT, LEWIN-VHI, INC., FAIRFAX, VA.

Dr. RUBIN. Thank you. I would like to very briefly summarize my remarks.

I am reminded that when I had a different position and Mr. Jacobs was chair of the subcommittee, I was successful at winning a prize for the most succinct testimony on a particular day. While I don't think I am going to break that record of 75 seconds, I will try my best.

Defensive medicine, as we understand it, constitutes elements of practice that do not provide benefit to patients and are carried out by physicians and medical institutions solely to avoid malpractice claims. This is what is known as positive defensive medicine, Mr. Chairman, which is what you have been discussing here today.

There is also something called negative defensive medicine. This is carried out by physicians and institutions that seek to avoid high-risk patients, and is an example of a practice that clearly would have an adverse effect on access to care. We haven't really had an opportunity to talk about negative defensive medicine, and

indeed the study that we performed, which you referred to earlier today, did not address this practice.

Clearly, there is a widespread government-private sector interest in tort reform, which is why we are having these hearings today. Tort reform is viewed as a way to reduce health care costs.

The goal of our study was to assess the cost of defensive medicine and, more importantly, to provide a framework for estimating the likely effects of tort reform on these costs. Defensive medical practices have been identified in a variety of clinical procedures, including presurgical testings. The clinical peer review literature suggests that at least $2.7 billion a year could be saved if we eliminated defensive presurgical studies; electronic fetal monitoring, where the Centers for Disease Control and Prevention believes that in excess of $1 billion could be saved if we only could adhere to the standards put forth by Health in the Year 2000; and skull x rays, where we estimate that about $178 million a year could be saved. And, indeed, in Maine the use of guidelines has cut the use of spine x rays following automobile accidents from 95 percent to 50 percent, resulting in substantial savings to the system.

While we can't assess the exact amount of excess utilization that may be attributed to fear of medical malpractice suits, we estimate that defensive medicine costs resulting from these procedures alone is close to $4 billion.

Claims of total available savings on defensive medicine, made by various Members of Congress, range from zero to $52 billion annually. Our middle range estimate of potential savings and the one that we believe is reasonable, would be roughly $4.3 billion in 1994, or a total of $35.8 billion between 1994 and 1998.

It is clear that a variety of factors other than defensive medicine may motivate physicians to order excessive tests or perform unnecessary procedures, including financial incentives, patient preferences, or prevailing standards of practice. It is obvious that no means of distinguishing among these factors has been devised. However, substantial savings in the cost of defensive medicine are likely to be achieved through reform. System-wide savings are clearly increased if financial and other incentives to provide unnecessary care are addressed simultaneously.

With that, I would like to end my statement, and would be happy to answer any questions.

[The prepared statement follows:]

Statement of

Robert J. Rubin, M.D.
President, Lewin-VHI, Inc.

Before

Subcommittee on Health
of the
Committee on Ways and Means

United States House of Representatives

May 20, 1993

My name is Robert J. Rubin. I am the President of Lewin-VHI, Inc., a health care consulting company. This morning I will present the results of our study "Estimating the Cost of Defensive Medicine" which was done under contract for the MMI companies.

I. INTRODUCTION

The future of health reform depends critically on identifying sources of inefficiency in the health care system, and devising ways of eliminating them. Against this background, many individuals and organizations have recently proposed reform of the malpractice insurance system, which is widely viewed as highly inefficient and costly. One of the prime targets invoked by those advocating reform is "defensive medicine", care that does not benefit the patient, and is provided solely to avoid malpractice claims. However, little is known about the potential effects of malpractice reform on the system-wide costs imposed by defensive medicine. The purpose of this effort is to review the literature on various estimates of national spending on defensive medicine, and to assess conflicting claims of potential cost savings to be garnered by curbing the practice of defensive medicine.

Published estimates of the costs of defensive medicine are subjective and critically dependent on a variety of assumptions. Perhaps most important, it is impossible to determine the motivations of a physician who orders excessive tests or carries out unnecessary procedures. In addition to the fear of malpractice litigation, physicians currently face a variety of other incentives to over-prescribe, including:

- Patient preferences to pursue highly aggressive treatment;
- Requirements of peer review organizations and hospitals;
- Financial incentives (e.g., fees from procedures);
- Premature application of new medical technologies;
- Lags in response to new clinical information.

Because no empirical study has been able to distinguish among these potential causes of over-use, any estimate of the overall savings that might result from elimination of defensive medical practices will depend on what is assumed about physician behavior. Other unknowns, discussed below in some detail, include the likely effect of changes in the malpractice system on physician behavior; the amount of time required to adjust to new behavioral incentives; and the rate of growth in defensive medical costs over time.

There are, however, a number of examples from the clinical literature that strongly suggest that defensive medicine is widely practiced in the United States. These medical practices are naturally observed in high-risk specialties, and include: pre-surgical tests; electronic fetal monitoring; and skull x-rays. Although it is difficult to determine exactly what fraction of these practices are carried out defensively, they probably account for more than $2 billion in costs annually.

We then review published estimates of the overall system-wide costs of defensive medicine, and use these sources to estimate the potential effects of a variety of malpractice reform efforts. Our middle-range estimate of potential defensive medicine savings from comprehensive malpractice reform is $4.3 billion in 1994 and a total of $35.8 billion between 1994 and 1998 (these figures include both hospital and physician costs). Because there are so many unanswered questions on the effects of malpractice reform, our quantitative analysis is critically dependent on a variety of assumptions that importantly affect the final results, including: the initial costs of defensive medicine, and the fraction of these costs that can be saved by reform of the malpractice system. To acknowledge this uncertainty, our model generates a range of estimates for each policy initiative under differing assumptions.

II. Defending Defensive Medicine

Before discussing quantitative estimates of defensive medicine costs or estimating the effect of malpractice reform, it is important to establish just what is meant by defensive medicine. We define defensive medicine as *changes in practice carried out by health care providers for the **sole** purpose of avoiding malpractice claims.* There are two types of actions that can be considered defensive:

- **Positive defensive activities** (i.e., tasks or procedures performed because of perceived malpractice risk) include diagnostic tests, performance of additional procedures, calling in consultants/subspecialists, increased record-keeping, more follow-up visits, and excess time spent with patients.

- **Negative defensive practices** (i.e., tasks or procedures not performed because of perceived malpractice risk) may include restricting practice to low-risk patients, ceasing to perform high-risk procedures, and retiring from practice due to liability worries.

While both types of defensive medical practice impose real costs on the health care system, there are no published quantitative estimates of the costs of negative defensive medicine.

As discussed above, there are a variety of possible motivations for physicians to perform excess tasks or procedures aside from defensive medical practice, including: patient preferences, financial incentives, and lack of information on the part of the practicing physician. Some have also speculated that physicians occasionally use new technologies before they have become a scientifically verified proper standard of practice.[1] To illustrate the complex process of appraising often nebulous and overlapping motivations, consider the situation of obstetricians faced with the decision of whether to deliver an infant by Cesarean section or to allow the birth to proceed normally.

- The surge in the number of C-sections performed over the last twenty years may be attributed to a change in the definition of "good obstetrical practice" due to the technological development of fetal monitoring systems.

- Some contest, however, that physicians choose to perform C-sections merely to reap financial rewards. According to an HIAA study, C-section charges average $7,186, compared with an average of $4,334 for a normal delivery.[2]

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[1] In a March 1, 1990 editorial in The New England Journal of Medicine, Roger Freeman writes of "the need for proper randomized trials before new forms of technology are introduced that may become the standard of practice without clearly demonstrated benefit."

[2] It should be noted that the charges listed in the HIAA study are hospital charges; physician charges for a C-section actually would add somewhere between $1,800 and $2,000 to the costs.

- And, of course, there is the belief that providers are influenced by the legal consequences of birthing decisions. Obstetricians have one of the highest malpractice premium levels of all specialists, due, in large part, to sizable awards rendered in birth injury negligence cases.[3]

A second factor that complicates the measurement of defensive medicine is the notion of "low-benefit" care. Our definition of defensive medicine implies *that any procedure performed with the expectation of benefiting the patient is **not** defensive medicine.* We recognize, however, that many interventions (e.g., sophisticated diagnostic imaging) are carried out when the expected potential benefit to the patient is extremely small. To the extent that extremely low benefit procedures are carried out to avoid malpractice risk, we may have understated the costs of defensive medicine.

Finally, in considering the true costs of defensive practice, it is also important to recognize that one of the purposes of the malpractice system is to send signals to physicians and other health care providers regarding appropriate treatment of patients in order to deter negligence. In a properly functioning legal environment, adjustment of providers' practice patterns in accordance with legal expectations should actually result in perceived social benefits.[4] This view is taken by Patricia Danzon, who points out that there are many benefits stemming from the malpractice system that counter-balance the excess costs. She estimates that even if malpractice laws are only responsible for a 12 percent reduction in the incidence of negligent injury, then the tort system pays for itself despite the potentially high costs of defensive medicine.[5] Others, however, look upon the system less favorably, and believe that failures in the malpractice system have resulted in a variety of inefficiencies, and that the costs (such as defensive medicine) exceed the benefits of the legal system's successes.

A. Prior Estimates of PLI Costs

Because of the many analytic problems associated with estimating the costs of defensive medicine, little empirical work has been done. In fact, there is only one peer-reviewed article estimating the costs of practice liability insurance, and other available estimates are either derived from this study, or constructed using cruder estimation methods.

Roger Reynolds of the AMA Center for Health Policy Research used Socioeconomic Monitoring System Survey data to develop two estimates of the impact of Professional Liability Insurance (PLI) on the cost of physicians' services. The two estimates of the total cost of PLI in 1984 are $13.7 and $12.1 billion, or approximately 15 percent of the total expenditures on physicians' services.[6] The first approach, which generated the larger of the two estimates, uses direct data on PLI premiums, practice changes physicians have made in response to increased claims risk, and other costs of incurring malpractice claims to derive estimates of the major components of PLI costs. The second employs a multivariate analysis to infer costs from the impact of variations in PLI premiums on physicians' fees and utilization rates for a range of procedures. These figures were updated to $15.1 billion in 1989 dollars by Moser and Musaccio.[7]

The Reynolds paper is not focused specifically on defensive medicine, but rather on the more general topic of costs associated with practice liability insurance. The first estimation method relies on self-reported values from physicians, which is suspect because physicians have a direct financial incentive to over-report their costs.

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[3] James Reuter, "Defensive Medicine and Medical Malpractice," Congressional Research Service Report, 7 August 1984.

[4] Nick Black, "Medical Litigation and the Quality of Care," Lancet 6 January 1990: 35-37.

[5] Testimony by Patricia M. Danzon, presented to the Committee on Labor and Human Resources, U.S. Senate, 10 July 1984.

[6] Reynolds et. al., "The Cost of Medical Professional Liability, JAMA, 22 Vol. 257, No. 20, May 1987: 2776-2781.

[7] J. Moser and R. Musacchio, "The Cost of Medical Professional Liability in the 1980s," Medical Practice Management, Summer 1991.

This method also overstates costs because it includes factors such as physician time that might not actually be billed to patients. The second method uses regression analysis to estimate the increase in fees associated with higher malpractice costs. This method might also overstate the costs of defensive medicine, since increases in fees might not accurately reflect the real costs borne by physicians. In addition, there are a variety of factors other than defensive medicine that might be associated with increased physician fees and higher malpractice premiums. Because these are the only peer reviewed estimates available, we have used them in our empirical analysis (Section V below). We reduced them, however, to reflect the notion that they include a variety of extraneous factors and thus overstate the costs of defensive medicine.[8]

III. CLINICAL EXAMPLES AND ASSOCIATED COSTS

A number of clinical examples strongly suggest that defensive medicine is practiced by American clinicians, and carries substantial costs. Three such interventions, discussed below, originate from specialties that are high in risk and carry substantial malpractice premium costs. Our intent in highlighting these interventions is to give concrete examples of costs incurred and also to arrive at a rough lower-bound to compare with our later estimates of defensive medicine costs.

A. Anesthesia

In a recently-accepted peer-reviewed journal article, Drs. Macario, Roizen, and colleagues reviewed over 2,000 medical records, and found that elimination of a variety of unwarranted lab tests could save more than $1.35 billion annually.[9] Extrapolating from these figures, Dr. Roizen has estimated that 60 percent of pre-operative testing is not needed; given that there are some 27 million operations per year in the U.S. and, on average, $165 is paid for pre-surgical testing for each. Roizen believes that about $2.7 billion could be saved through more efficient testing.

The key issue is trying to separate out what portion of this total constitutes defensive medicine, and what portion is unnecessary practice due to other factors. Roizen believes that these unnecessary practices originated as a result of fear of malpractice, but continue merely because of a lack of communication between attending physicians and anesthesiologists. He further states that the development of effective guidelines that are defensible in court should be able to eliminate this waste from the system. We believe this a credible position. It is unlikely that financial considerations play a significant role in the ordering of excessive tests, since anesthesiologists are typically not paid for them. It is equally unlikely that patient preferences play a role. While it is difficult to attribute the entire $2.7 billion to defensive medicine, in the absence of other possible causes, we conclude that an appreciable portion results from fear of malpractice suits.

B. Obstetrics/Gynecology

Continuous intrapartum monitoring of the fetal heart rate (commonly referred to as "fetal monitoring") was historically considered by many clinicians to be superior to intermittent auscultation.[10] In 1978, it was estimated that at least two thirds of pregnancies in the United States were electronically monitored during labor. However,

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[8] It is worth noting that these figures were used erroneously as a basis for estimating the costs of defensive medicine in former President Bush's health reform proposal. The Bush Administration proposal claimed that $20.7 billion, or 17.6 percent of total physician expenditures resulted from defensive medical costs, and cited Moser and Musacchio. However, this figure included premium costs in addition to other costs of practice liability insurance.

[9] Alex Macario, Michael F. Roizen, et. al. "A Tale of Three Cities: Has Reassessment of Preoperative Laboratory Testing Changed the Test-Ordering Patterns of Physicians?" Journal of Surgical Gynecology and Obstetrics. Forthcoming. Interestingly, the article also indicates that some services that are being eliminated are in fact useful.

[10] Kenneth J. Leveno et. al., "A Prospective Comparison of Selective and Universal Electronic Fetal Monitoring in 34,995 Pregnancies," New England Journal of Medicine 4 September 1986: 615.

according to a study published in The New England Journal of Medicine in 1986,[11] "not all pregnancies, and particularly not those considered at low risk of perinatal complications, need continuous electronic fetal monitoring during labor". A subsequent study in the Journal concluded that "as compared with a structured program of periodic auscultation, electronic fetal monitoring does not result in improved neurologic development in children born prematurely".[12] Electronic fetal monitoring, though, has been in wide use since its introduction into obstetrical practice for several reasons including, according to Dr. Myra Gerson Gilfix, "fear [of] malpractice suits for failing to use an available 'customary procedure'".[13]

It is difficult to assess the costs of fetal monitoring because the costs incurred are associated with a wide range of cost centers. They include the direct costs of electronic fetal monitoring and the costs of a Cesarean section required as a result of the monitoring. Both components are associated with complications and occasional morbidity. In a 1979 article, H. David Banta and Stephen B. Thacker estimated these costs at $0.4 billion annually, but also noted that these costs were increasing over time.[14] Assuming that the costs of fetal monitoring increased at about the same rate as overall personal health expenditures, we estimate that the current annual costs of fetal monitoring are close to $1.0 billion. Although physicians are reimbursed for these procedures and would also receive payment for the associated Cesarean section delivery, based on the above literature, it is likely that a significant portion of these costs resulted from defensive medicine.

C. Emergency Department

Although the value of skull radiography in identifying intracranial injury has not yet been satisfactorily defined, most emergency room physicians routinely order skull x-ray examinations after head trauma. Stuart Masters et. al. argue in a New England Journal of Medicine article that a clearly delineated management strategy for the use of skull radiography can effectively diminish the use of skull x-rays and bring about savings of millions of dollars annually without missing intracranial injuries.[15] Many emergency physicians believe that defensive medicine is the only reason why routine skull x-rays are ordered. For example, Dr. Jesse Cole has written in the New England Journal of Medicine that physicians order films mostly "to protect themselves from possible lawsuits" as the decision to refrain from ordering these x-rays often involves "subjective findings that are open to debate".[16]

Masters et. al. estimate that roughly 53 percent of the 2.4 million skull x-rays ordered on an emergency basis are unnecessary. Assuming a cost of $140 per procedure,[17] we estimate that unnecessary skull x-rays are responsible for about $178 million annually. It is likely that the bulk of these costs result from defensive medicine, since physicians typically do not have direct financial interests in such procedures, and because patient preferences are unlikely to play a substantial role.

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[11] Leveno et. al., 1986: 615-619.

[12] Kirkwood K. Shy et. al., "Effects of Electronic Fetal-Heart-Rate Monitoring, as Compared with Periodic Auscultation, on the Neurologic Development of Premature Infants," The New England Journal of Medicine 1 March 1990: 588-593.

[13] Myra Gerson Gilfix, "Electronic Fetal Monitoring: Physician Liability and Informed Consent," American Journal of Law and Medicine vol. 10, no. 1, 1984: 32.

[14] H. David Banta and Stephen B. Thacker. "Assessing the Costs and Benefits of Electronic Fetal Monitoring." Obstetrical and Gynecological Survey. Vol. 34, No. 8; 1979: 627-42.

[15] Stuart J. Masters et. al., "Skull X-Ray Examinations After Head Trauma: Recommendations be a Multidisciplinary Panel and Validation Study," The New England Journal of Medicine 8 January 1987: 84-91.

[16] Jesse Cole, New England Journal of Medicine, Correspondence, Vol. 317, No. 5, 30 July 1987: 317.

[17] This figure is a rough estimate obtained by surveying a number of hospitals.

IV. POTENTIAL POLICY INTERVENTIONS

A number of interventions have been proposed to address defensive medicine costs and other problems with the malpractice system. Just as there is uncertainty regarding the extent of the defensive medicine costs, there is also uncertainty regarding the potential effects of proposed interventions.

First, as discussed earlier, practices that appear defensive in nature might be caused by a variety of other factors, including financial incentives, patient preferences, or lack of current information. Interventions that address many of these concerns simultaneously are thus more likely to be effective.

Second, it is important to recognize that physicians may be motivated more by the threat of lawsuits than by the actual cost of litigation. Lawsuits often carry many costs beyond what is paid through the judicial system, including: missed work, disciplinary actions, and the loss of practice liability insurance. In addition, there are also considerable indirect costs imposed on the physician, such as increased stress and the potential for injuring one's reputation and relations with colleagues. For these reasons, malpractice reforms that reduce the potential of being sued are more likely to modify physician practice patterns than are proposals which merely limit awards.

Third, current proposals vary substantially with respect to how specific they are in describing how reforms are to be implemented. Some proposals are highly specific in what they propose to do and how they propose to solve potential problems, while others are vague. In addition, while some policies show "teeth" behind them to promote effective enforcement, others have no enforcement provisions. Of course, program effectiveness will ultimately be highly dependent on the way in which the proposed programs are implemented.

A. Physician Immunity Against Suits

Many current health reform proposals include the development of medical practice guidelines, which are expected to reduce costs and increase the effectiveness of physicians. Guidelines have also been proposed as an answer to the defensive medicine problem: the hope is that by establishing guidelines and granting physicians immunity from suits that involve care that was given according to these guidelines, physicians will not need to provide care in a defensive fashion.

Although this idea appears both appealing and feasible, we believe that in and of itself it is likely to be of only limited effectiveness in the near future. The reasons include the following: The plan would require a law that supports the concept and limits the ability of patients to sue or substantially reduces the probability of an adverse finding against the physician; It is likely that it would take some time before physicians would trust that the guidelines would actually stand up in court; While the proposal might decrease awards, it would be unlikely to appreciably reduce the number of law suits in the near future; By itself, an indemnity plan would do nothing to affect factors other than defensive medicine that affect physician behavior (e.g., financial incentives); The development of a sufficient number of guidelines will probably take many years, judging from the experience of current Federal efforts.

B. Comprehensive Reform Proposals

By "comprehensive" reform, we mean a plan that simultaneously addresses the many aspects of the defensive medicine problem. This might include the following actions: Limit allowable non-economic damages for malpractice; Eliminate joint and several liability for non-economic damages; Eliminate the collateral source rule;[18] Require periodic, rather than lump-sum, payments for awards; Promote settlements through alternative dispute mediation (ADR); Establish alternative means of promoting

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[18] This rule allows for double recovery by not requiring that malpractice awards be reduced when compensation is received from other sources (e.g., health insurance).

quality;[19] Limit attorney's fees in malpractice cases as a percentage of the damages awarded to the patient. Establish state demonstration projects for alternative malpractice systems, such as mandatory administrative dispute resolution and reductions in the liability of physicians. Fund further research on topics including prevention of medical injuries and medical practice guidelines. Collect and disseminate information on the calculation of damages in malpractice cases, with the goal of establishing a standardized methodology for the calculation of awards.

C. No-fault Insurance

In response to dissatisfaction with our current malpractice system, several experts have pushed for the replacement of fault-based tort litigation with an administrative system in which the victims of adverse outcomes of medical care would be compensated for economic loss, regardless of negligence.[20] For example, one such proposal suggested that "a compensable medical injury would be defined as any illness, impairment, or death that was due to the act, or failure to act or diagnose, of a health care provider during the course of a medical examination or intervention, that was not within the reasonable range of medical outcomes that might occur as the result of a condition...Awards would cover net economic losses only."[21] Such a system would not be without precedent: Virginia and Florida have recently instituted no-fault systems to compensate parents for birth-related injuries to infants; the nations of New Zealand and Sweden have longstanding no-fault systems for medical injuries; and a no-fault system was proposed recently by the NY Commissioner of Health.[22]

Because no-fault insurance eliminates the ability of patients to sue physicians, we assume that, if adopted, virtually all costs of defensive medicine would disappear. The primary drawback with no-fault insurance is that it eliminates the ability of the patient to sue, and consequently, the deterrent effect of the malpractice system. For this reason, proposals to implement no-fault insurance typically also contain an alternative system for detecting and deterring negligent behavior.

V. QUANTITATIVE ESTIMATES OF POTENTIAL SAVINGS

The purpose of this next section is to estimate the potential savings from efforts to reduce the practice of defensive medicine. There is little reliable research on the total costs of defensive medicine, and the likely effects of efforts to reduce its incidence; for this reason, our quantitative estimates are dependent on a variety of assumptions, and we present a broad range of estimates to reflect this uncertainty.

A. Baseline Estimate of Professional Liability Costs in Excess of Premiums

Estimating total spending on medical malpractice liability insurance is difficult because much of the insurance currently held by physicians and hospitals is obtained through non-traditional sources, e.g., surplus lines insurance, self-insurance, captive insurance companies, and risk retention groups. Conning and Company has estimated that such markets comprise about 86 percent of spending on conventional PLI.[23] Best and Company has estimated that spending on conventional PLI in 1991 was $4.9 billion.[24] Total spending on malpractice liability insurance was thus about $9.2 billion.

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19 The plan proposes to promote enhanced quality of care through improved peer review, enhanced effectiveness research, and increased efforts to develop guidelines and standards for quality and performance.

20 Arnold S. Relman, "Changing the Medical Malpractice Liability System," The New England Journal of Medicine, Vol 322, No. 9, 1 March 1990: 626.

21 Barry M. Manuel, "Professional Liability - A No-Fault Solution," The New England Journal of Medicine. Vol. 322, No. 9, 1 March 1990: 627.

22 Sack, K. "No-Fault for Doctors is Called Feasible," NYT, 1 March 1990: 83.

23 Conning and Company, "Property Casualty Alternative Markets' Update." July, 1991.

24 Best and Company, "Best Database Service: Property/Casualty Experience by Line," 1991.

To estimate the total costs of practice liability insurance excluding premiums, we multiply $9.2 billion by 2.7, to arrive at $24.8 billion.

B. Other Possible Motivations for These Practices

As discussed in Section IV above, it is impossible to determine what is going through the mind of a physician who orders excessive tests or procedures. We believe that the estimates generated by Reynolds include costs incurred due to financial motivations, patient expectations, and lack of current clinical information. Because we are unable to estimate the exact influence of these factors, we estimate the costs of defensive medicine under three scenarios:

- Scenario I assumes that defensive medicine accounts for 20 percent of professional liability costs in excess of premiums ($5.0 billion in 1991);
- Scenario II assumes 40 percent ($10.0 billion in 1991);
- Scenario III assumes 60 percent ($14.9 billion in 1991).

We believe that our clinical examples support Scenario I as a lower bound on the amount of defensive medicine that is currently practiced in the United States. Our three examples account for almost $4 billion of costs. Even if one assumes that half of these costs resulted from factors other than defensive medicine, that leaves only $3 billion to be accounted for in the hundreds of billions of dollars of acute care costs that we have not scrutinized.

C. Potential Future Savings Associated with Malpractice Reform

Although we have estimated the costs of defensive medicine, it remains unclear how much, if anything, can be saved through reform of the malpractice system. As discussed in Section IV above, the effectiveness of proposed reforms will depend on a range of factors, including: the comprehensiveness of a proposal; whether the proposal is likely to reduce the number of suits brought against physicians in addition to simply reducing awards; and the likely enforcement of any plan. In Section IV we describe four proposed plans for reforming the malpractice system. To generate our savings estimates, we assume the following savings following full implementation:

- Indemnify physicians assumes 25 percent savings;
- Comprehensive Reform assumes 60 percent savings;
- No fault insurance assumes 85 percent savings.

These rough estimates reflect the fact that it is impossible to precisely model the impact of proposed legislation without further details and better research on the effects of reform.

Policy changes are not likely to effect immediate behavioral change in physicians; instead, changes in a physician's patterns are likely to change slowly over time as trust in the new malpractice system builds and as the physician adjusts to new clinical practices. To estimate the lag in adoption of new proposals, we have modeled the time lag after that observed by the MMI Risk Modification Program. The data from this project describe the speed with which physicians adapt to a new clinically indicated practice protocol, and indicate that the gain is achieved gradually over a 4 year period. While the speed with which a given plan is adopted might actually vary from plan to plan, we do not have sufficient information to model such differences. Finally, we also assume that the costs of defensive medicine in both the hospital and physician sectors will rise in the future at the same rate as costs in both of those sectors.

D. Range of Quantitative Estimates

We assume that the first year in which savings will be incurred is 1994. All of our estimates begin in 1994 (the first full year likely to see reform) and are expressed in 1991 dollars. Our "middle projection" estimate for savings in 1994 is $4.3 billion; this figure is based on the following calculation and assumes:

- *Assumption:* PLI costs other than premiums are 2.7 times premiums; premiums accounted for about $9.2 billion in 1991.

Implication: PLI costs other than premiums account for $24.8 billion in 1991.

- *Assumption:* Defensive medical practice composes 40% of PLI costs other than premiums.
Implication: Defensive medical practice accounts for $9.9 billion in costs in 1991.

- *Assumption:* Defensive medical costs will rise by 6.2% annually, as did other acute care costs over the past decade.
Implication: In 1994, the first year of savings, defensive medical costs will be $11.9 billion.

- *Assumption:* Malpractice reform short of no-fault will eliminate about 60% of available defensive medical costs.
Implication: Maximum possible 1994 savings would be $7.1 billion.

- *Assumption:* Only 60% of the full savings is achieved in the first year, due to gradual phase-in of regulation.
***Implication:* Estimated 1994 savings from reform efforts would be $4.3 billion (in 1991 dollars).**

Our smallest estimate for serious reform of the malpractice system is $0.9 billion, which assumes no-fault insurance would save 25 percent of defensive medical costs and that 20 percent of professional liability costs other than premiums stem from defensive medicine. Our largest estimate is $9.2 billion, which assumes that a plan for no-fault insurance would save 85 percent of defensive medical costs and that 60 percent of professional liability costs other than premiums stem from defensive medicine. Once achieved, the savings from eliminating defensive medicine will accrue each year. Our estimates of the 5-year savings from serious malpractice reform range from $7.5 to $76.2 billion.

VI. CONCLUSIONS

Defensive medicine has been hailed by some observers as a potentially major part of the solution for the rise in health care costs; others have dismissed defensive medicine, claiming that no savings can be achieved. We define defensive medicine as *changes in practice carried out by health care providers for the purpose of avoiding malpractice claims.* We include both physician and hospital costs, and make critical assumptions regarding the prevalence of defensive practices, and the potential effects of efforts to reform the malpractice system. All of our estimates assume that serious and far-reaching reform is adopted, as described in Section V. Our middle-range estimate of savings in 1994 is $4.3 billion. The estimates of savings in 1994 range from $0.9 billion under indemnifying physicians, to $9.2 under no-fault insurance (1991 dollars). Five-year estimates range from $7.5 to $76.2 billion with a middle-range estimate of $35.8 billion.

One of the primary reasons why there is such a wide range in these estimates is that defensive medicine is a difficult concept to define. There are a variety of reasons why a physician might perform services that are not warranted, including financial incentives, patient expectations, and lack of current clinical information. The wide range of potential motives, which are also likely to overlap in many cases, make it virtually impossible to isolate the contribution of defensive medical costs. Estimates of defensive medical costs ultimately depend on what is assumed regarding physician motivation.

The disparate estimates in the literature also reflect a lack of conclusive research on the potential effects of malpractice reform. Because the provision of unnecessary care is so multifaceted, we believe that efforts to eliminate defensive medicine are likely to work well only if they address financial incentives, make serious efforts at changing professional behavior, answer potential liability questions, and consider a range of other factors. Such efforts must clearly address more than the dollar amount of awards, which do not account for the stress and other non-monetary costs that stem from suits. The effectiveness of future programs will also depend on their acceptance by the courts, physicians, and the public.

Chairman STARK. Ms. Gilbert.

STATEMENT OF PAMELA GILBERT, DIRECTOR, PUBLIC CITIZEN'S CONGRESS WATCH

Ms. GILBERT. Thank you, Mr. Chairman.

I am the director of Public Citizen's Congress Watch. Public Citizen has 140,000 members across the country. We are a consumer organization founded by Ralph Nader. Congress Watch is the lobby arm of Public Citizen.

My organization has long been active in efforts to reform the Nation's health care system and to improve the quality of medical care. I am very happy to be here today to testify to present our very strong view that restricting the rights of victims of medical malpractice will not significantly reduce the cost of health care or medical malpractice insurance, but will be detrimental to efforts to improve the quality of health care and it will penalize some of the most vulnerable members of our community, those who have been victimized by negligent medical care.

There is a virtual epidemic of medical malpractice in this country. Public Citizen has looked at the results of three different studies and we estimated that between 150,000 and 300,000 Americans are injured or killed each year by doctor negligence. If you extrapolate from the 1991 study by Harvard that has been discussed already today, approximately 80,000 deaths occur annually due to doctor negligence. That is more than twice the number of motor vehicle occupants killed every year.

Yet most attempts to address the problem of medical malpractice have been embodied in attacks on victims and their right to recover damages from negligent providers, not on solving the problem at the source: insuring quality care and eliminating medical negligence.

Limiting the ability of people to bring lawsuits is even more inappropriate when you look at the small number of malpractice victims who ever bring a claim or get compensated through the courts. The fact is that Americans rarely use the courts for accident compensation.

Again, if you look at the Harvard study, only one in eight negligently injured patients filed a claim to recover damages. And 16 times as many patients suffered an injury from medical negligence as there were patients who received compensation from the malpractice system.

The study concluded:

> Our problem is not a litigation surplus, but a litigation deficit. The gap between torts occurring in American hospitals and torts being filed in American courts is far greater than has ever been supposed.

Even so, there is currently an effort under way to use the upcoming proposal to address the national crisis in health care as a vehicle for the same shopworn proposals that the American Medical Association has been pushing for two decades.

They claim that limiting victims rights is a solution to the skyrocketing cost of the health care system. In fact, nothing could be further from the truth. Medical malpractice costs make up a minuscule part of overall health care costs. In 1991, medical mal-

practice insurance premiums were only 0.6 percent of total health care costs.

We could completely eliminate the right of victims of medical negligence to recover for their losses and we would barely make a dent in the cost of the overall health care system, if in fact we reduce those costs at all.

Advocates of limiting victims rights often argue that it is not just insurance premiums that make the system expensive but it is defensive medicine, medical practices that are not in the best interests of the patient but are performed to avoid liability. But so far, no one has been able to adequately measure the amount of defensive medicine that exists, nor to precisely identify its cause.

So-called defensive medicine may simply be good careful medicine. In addition, much care labeled defensive medicine may be the result of physician self-dealing, profitable referrals for testing at facilities in which the doctor has a financial stake.

Mr. Rubin just testified about his study on defensive medicine costs which, in fact, concluded that savings from malpractice restrictions would be between $4 and $9 billion a year in defensive medicine costs, and that is according to his study based on assumptions that, frankly, my organization doesn't accept.

But that study also concluded that: "Defensive medicine is a difficult concept to define. There are a variety of reasons why a physician might perform services that are not warranted, including financial incentives, patient expectations, and lack of current clinical information. The wide range of potential motives, which are also likely to overlap in many cases, make it virtually impossible to isolate the contribution of defensive medicine costs."

The Congressional Budget Office testified before this committee in 1992 that malpractice laws would not reduce health care costs. The CBO said, "moreover, if the system of medical malpractice liability were modified, the resulting change in national health expenditures would be uncertain, and if any reductions occurred, their magnitude would probably be small. In fact, much of the care that is commonly dubbed defensive medicine would probably continue to be provided for reasons other than concerns about malpractice. Finally, any reductions generated by a different malpractice system might be offset by an increase in other medical services including high risk ones either for therapeutic reasons or as a response to reductions in physicians' income."

I will conclude my remarks here because I see that my time is up. I just want to reiterate that we believe it is quite ill-advised and contrary to the evidence to focus at all on the system of medical malpractice as any way to reduce health care costs or to help make health care more affordable.

Rather than enacting proposals to restrict the legal rights of U.S. citizens, the health care debate should focus on providing adequate health insurance and ensuring high quality care for all. We believe if we do that, not only will we reduce the incidence of medical malpractice and therefore reduce costs in the legal system, but we will help ensure adequate medical care for everybody in America.

Thank you.

[The prepared statement follows:]

TESTIMONY OF PAMELA GILBERT
PUBLIC CITIZEN'S CONGRESS WATCH

I am Pamela Gilbert, director of Public Citizen's Congress Watch. Public Citizen, with over 140,000 members nationwide, is a consumer organization founded by Ralph Nader. Congress Watch is the lobbying arm of Public Citizen. Public Citizen has long been active in efforts to reform the nation's health care system and to improve the quality of medical care. I appreciate the opportunity to present our strong view that restricting the rights of victims of medical malpractice will not significantly reduce the costs of health care or medical malpractice insurance, will be detrimental to efforts to improve the quality of health care, and will penalize some of the most vulnerable members of our community -- those who have been victimized by negligent medical care.

INTRODUCTION

There is a virtual epidemic of medical malpractice in this country. Public Citizen estimates that between 150,000 to 300,000 Americans are injured or killed each year by doctor negligence. Extrapolating from a study conducted by Harvard Medical School, approximately 80,000 deaths occur annually due to doctor negligence -- more than twice the number of motor vehicle occupants killed each year. Yet, most attempts to address the problem of medical malpractice have been embodied in attacks on victims and their right to recover damages from negligent providers, not on solving the problem at the source -- ensuring quality care and eliminating medical negligence.

Now, the American Medical Association and its lobbyists want to use President Clinton's proposal to address the national crisis in health care as a vehicle for the same shop-worn proposals to restrict the legal rights of victims that the medical society has been pushing for two decades. They claim that limiting victims' rights is a solution to the skyrocketing costs of the health care system. Nothing could be further from the truth. In fact, medical malpractice costs make up a minuscule part of overall health care costs. Even if we completely eliminated the right of victims of medical negligence to recover for their losses, we would make barely a dent in the costs of the health care system, if in fact those costs would be reduced at all.

The greatest impact of restricting access to the courts would be felt by the victim of negligent care who might receive little or no compensation. In addition, relieving negligent doctors of responsibility for paying for the costs of their victims' injuries does not mean that these costs would disappear. Someone would have to pay for those injuries, whether it is the victims themselves or taxpayer-financed programs. This would not save the country health care costs, it would simply redistribute those costs from the wrongdoers to innocent parties. Finally, reducing victims' rights could even increase the costs of the health care system by decreasing the deterrent effects of the system. Reducing deterrence would likely lead to more injuries from malpractice, and hence, higher health care costs.

It is an insult to the tens of millions of uninsured and underinsured Americans to suggest that any part of the solution to the unavailability of affordable health care is to take away compensation from people who have been injured by careless doctors. Rather than enacting proposals to restrict the legal rights of U.S. citizens, the national health care debate should focus, instead, on providing adequate health insurance and ensuring high quality care for all. In fact, by ensuring access to health care for everyone, we would do more to reduce the number of malpractice lawsuits than restricting legal rights could ever accomplish. After all, if an injured person's medical bills are paid for, there would be little incentive to bring a lawsuit to collect compensation. A recent study of liability law and compensation in 10 countries conducted by the Insurance Information Institute, an insurance industry-funded research organization, concluded that other countries have far fewer personal injury lawsuits than the U.S. largely because those countries have a much greater availability of government entitlement programs, including national health care and more expansive workers' compensation systems.

The United States has the resources to provide adequate health care to all its residents and to adequately compensate the unfortunate victims of medical malpractice. Public Citizen believes that a single-payer health care program similar to the Canadian system could provide universal health care in the U.S. for the same cost as our current inadequate system, without curbing the

rights of malpractice victims. The solution to the serious problem of malpractice, on the other hand, is to prevent the injuries in the first place through improved doctor discipline efforts, better training, and by opening up the National Practitioners' Data Bank for use by the public.

THE PROBLEM OF MEDICAL NEGLIGENCE

Medical negligence occurs too frequently.

There is a virtual epidemic of death and injury due to negligent medical care in this country. According to a 1991 Physician Payment Review Commission report: "the evidence is compelling that rates of inpatient medical injury and negligent medical injury are substantial."[1] Public Citizen estimates that between 150,000 and 300,000 Americans are injured or killed each year by doctor negligence, based on the results of three studies of hospital patients:

The 1991 Harvard Medical Practice Study of New York hospitals found that medical negligence caused one percent of hospital patients to suffer an injury which prolonged their hospital stay.[2] Using this figure and extrapolating to all admissions in New York State in 1984, according to the study, negligence of doctors or hospital staff contributed to approximately 4,000 hospital deaths and an additional 23,000 injuries. Applying these figures nationwide would mean that in 1988, 234,000 injuries and 80,000 deaths were caused by negligence in American hospitals. This is more than twice the number of fatalities of motor vehicle occupants occurring each year.

Similarly, a study of hospital inpatient records in California found that 0.8 percent of patients were injured by medical negligence in 1974.[3] Extrapolation of those findings yields an estimate of 249,000 injuries and deaths from negligence in 1988.

In 1976, the Department of Health, Education and Welfare's Malpractice Commission estimated that one-half of one percent of all patients entering hospitals are injured there due to negligence.[4] That estimate would indicate 156,000 such injuries and deaths resulted from doctor negligence in 1988.

Furthermore, the RAND Corporation studied records of 182 patients who died in hospitals in 1985.[5] Three independent physicians reviewed the files and found 14 - 27 percent of the deaths were probably preventable. The study also found evidence that "a small number of factors caused most preventable deaths. In fact, nine reasons encompassed all of the issues identified by the physician panel."

As troubling as these findings are, the studies actually underestimate the rate of medical malpractice. First, the studies do not include death and injury from negligence that occurs outside a hospital setting. Second, the findings include only incidents of negligence that actually result in injury. The studies do not measure the occurrences of substandard care that have the potential to produce injury but, fortunately, do not result in injury.

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[1] Physician Payment Review Commission: Annual Report to Congress, 1991, p. 364.

[2] Brennan, Troyen and others, "Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I," New England Journal of Medicine, February 7, 1991.

[3] Mills, Don, ed., Report on the Medical Insurance Feasibility Study (San Francisco: California Medical Association and California Hospital Association, 1977).

[4] Journal of Legal Medicine, February, 1976.

[5] Danzon, Patricia, "The Frequency and Severity of Medical Malpractice Claims: New Evidence," Law and Contemporary Problems, 1986.

The medical malpractice system helps to compensate many victims of malpractice and to send a message of deterrence to care providers. But clearly, more needs to be done to prevent death and injury from negligent care.

Doctor discipline programs must be improved.

Improvements in disciplinary programs against doctors who commit malpractice could prevent a substantial number of incidents of malpractice. This is especially true because, according to a number of studies conducted in the past ten years, a small number of physicians are responsible for most medical malpractice claims. Therefore, by reducing incidents of negligence by those few doctors, most malpractice injury can be avoided.

The following brief review of some of these studies shows the extent to which a small percentage of doctors cause the majority of malpractice injuries:

* In Florida, 3 percent of doctors accounted for 45 percent of the claims paid during the years 1975-1984.[6] Another Florida study found that, between 1975 and 1980, 3 percent of medical specialty physicians accounted for more than 85 percent of that group's payments; 6 percent of obstetrics-anesthesiology physicians accounted for more than 85 percent of that group's payments; and 7.8 percent of the surgical physicians accounted for 75 percent of that group's payments.[7]

* In Los Angeles, 0.6 percent of doctors in a four-year period accounted for 10 percent of all claims and 30 percent of all payments.[8]

* A 1991 study of physicians covered by the primary physician-owned insurer in Tennessee found "a disproportionately small number of doctors are responsible for a disproportionately large frequency and severity of lawsuits."[9]

* In Pennsylvania, one percent of physicians accounted for 25 percent of losses paid over a ten year period.[10]

* A 1987 study of Cook County, Illinois found two percent of all physicians practicing in the county were defendants in 36 percent of all medical negligent litigation filed since 1973.[11]

* A 1987 Public Citizen study found that "7.5 percent of all practicing physicians in Texas are responsible for 65 percent of the reported claims filed between 1978-1984".[12]

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[6] "Medicine On Trial: The Malpractice Crisis," Orlando Sentinel, series beginning April 13, 1986.

[7] Sloan, et.al., Medical Malpractice Experience of Physicians: Predictable or Haphazard?, 262 J.A.M.A., 1989.

[8] Schwartz & Komesar, Doctors, Damages and Deterrence, 298 New Eng. J. Med., 1987.

[9] Schmidt, Windsor C., et.al., "Factors Asociated with Medical Malpractice: Result from a Pilot Study", The Journal of Contemporary Health Law and Policy, Volume 7, Catholic University of America, 1991.

[10] Hofflander and Nye, "Medical Malpractice Insurance in Pennsylvania," Management Analysis Center, 1985.

[11] Miller, Natalie, et.al., "Medical Malpractice: Crisis of Litigation or Crisis of Negligence?" Health Resources Inc., 1987.

[12] "Medical Malpractice in Texas: Are We Covering Up the Symptoms Instead of Curing the Disease?" Public Citizen, compiled from reports by the Texas State Board of Medical Examiners, 1987.

An increase in disciplinary actions against these recidivist doctors would substantially decrease the incidence of malpractice across the country. However, evidence compiled by the Public Citizen Health Research Group shows that, in general, negligent and incompetent doctors are rarely disciplined or removed from practice. According to the report "Comparing State Medical Boards," published by the Health Research Group, at most, about 0.5 percent of the nation's doctors face any sanctions at all from their state medical boards each year. The report found that in 1991, only 3.44 serious disciplinary actions (license revocations or suspensions, probation, surrender of license, loss of privileges, and limitations or restrictions of privileges) were taken per 1,000 physicians nationwide.[13] This is equivalent to 2,013 such actions in all of 1991 -- a pittance compared to the 150,000 - 300,000 who are injured or killed each year in hospitals as a result of medical negligence. (I would like to submit this report for the record of today's hearing.)

In addition to the low numbers of disciplinary actions taken by state licensing boards, the types of actions taken generally do not address the issue of poor quality care due to medical negligence. Instead, most states focus attention on physicians with drug and alcohol problems, occurrences that are easier to define and identify than incidents of negligent conduct. The fact that most states fail to exert the maximum possible effort to discipline negligent doctors is one of the most serious threats to the health of American patients, and a major reason why the legal system is so important as an adjunct to state regulatory actions.

RESTRICTING VICTIMS' RIGHTS IS NOT AN ANSWER TO THE HEALTH CARE CRISIS

Limiting legal rights will not lower health care costs.

The U.S. health care system is failing fast. The U.S. spent $838.5 billion on health care in 1992, and without significant reform, that figure is expected to exceed $1 trillion by 1994. This represents nearly 14 percent of the gross national product, up from 11.6 percent in 1989. Despite these massive expenditures, the U.S. ranks 12th worldwide in life expectancy; 21st in the number of deaths of children under age 5; and 22nd in infant mortality. Furthermore, between 37 million and 48 million Americans have no health insurance at all.

In order to avert disaster, this nation must reduce health care costs. Studies by the U.S. General Accounting Office, Physicians for a National Health Program, and Public Citizen show a potential savings in administrative costs between $60 and $135 billion if the U.S. adopts a single-payer health care plan similar to the system in Canada. By redirecting this wasteful administrative spending to health care, the U.S. could provide universal coverage for all Americans without spending more money on health care than we do today.

Rather than endorse this sensible and humane program, the American Medical Association claims that placing restrictions on victims' rights will lower costs and increase access to health care. Even if this were true, it would be unfair and cruel to cure the problems in the health care system on the backs of injured victims. In fact, however, limiting legal rights will not result in a cost savings in the health care system.

Medical malpractice costs are a minuscule fraction of overall health care costs. According to a report by the National Insurance Consumer Organization, in 1991, total health care costs in the U.S. were about $750 billion; medical malpractice insurance premiums that year were about $4.8 billion, or **0.6 percent of total health care costs.**[14] Contrast this with the administrative costs of the system, estimated to range from 10 percent to 25 percent of health care costs, or with doctors' income, estimated to make up about 15 percent of total costs.

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[13] VanTuinen, Ingrid, McCarthy, Phyllis, Wolfe, M.D., Sidney M. and Barne, Alana, "Comparing State Medical Boards," Public Citizen Health Research Group, January, 1993.

[14] "Medical Malpractice Insurance 1985-1991 Calendar Year Experience," National Insurance Consumer Organization, March, 1993.

Malpractice premiums also make up only a small part of most doctors' expenses. According to American Medical Association figures, in 1989, professional liability insurance premiums accounted for only 4.9 percent of revenues for the typical physician practice.[15] The largest expense was for nonphysician employee wages. That same year, the nation's largest medical malpractice insurer lowered its rates in 34 states.[16] And while insurance rates decreased in 1989, the average income of physicians increased by almost 8 percent that year, far more than the 4.6 percent rate of inflation. The increase brought doctors' incomes to $155,000, an increase of $11,100 over 1988.[17] The high cost of health care cannot be blamed on the small costs of protecting victims from negligent physicians.

Finally, the medical malpractice system may actually save money in the health care system because of its deterrent effect. According to Patricia Danzon of the Wharton School, "...if the number of negligent injuries is, generously, 20 percent lower than it otherwise would be because of the incentives for care created by the malpractice system, the system is worth retaining, despite its costs."[18]

Injured victims rarely bring lawsuits.

It is not surprising that malpractice costs make up a small portion of health care costs, since, on the whole, Americans rarely use the courts for accident compensation. According to a 1991 RAND study, only 3 percent of seriously injured victims involved in accidents not related to the workplace or automobiles file a liability claim.[19] An earlier Rand study concluded, "At most, one in ten incidents of medical malpractice results in a claim, and of these, less than half, or one in 25 receive payment."[20] Similarly, the 1991 Harvard Medical Practice study estimated that in 1984, only one out of eight negligently injured patients filed a claim to recover damages.[21] The study further found that 16 times as many patients suffered an injury from medical negligence as there were patients who received compensation from the medical malpractice system. The study concluded, "Our problem is not a litigation surplus, but a litigation deficit. The gap between torts occurring in American hospitals and torts being filed in American courts is far greater than has ever been supposed."

Likewise, a 1991 study by a committee within the American Law Institute states: "Deserving victims with legitimate claims continue to face high barriers to obtaining tort redress."[22] In short, few victims of malpractice ever bring a liability claim, and even fewer

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[15] Gonzalez, Martin L., Socioeconomic Characteristics of Medical Practice 1990/1991, American Medical Association, p.22.

[16] "Biggest Malpractice Insurer Cuts Rates in 34 States," Liability Week, Volume 4, No. 16, April 17, 1989.

[17] "Doctors' Average Income Reaches $155,000," Federal and State Insurance Week, December 14, 1990.

[18] Danzon, Patricia M., Medical Malpractice: Theory, Evidence, and Public Policy, Harvard University Press, 1985.

[19] Hensler, Deborah R., et.al., Compensation for Accidental Injuries in the United States, Rand Corporation, Institute for Civil Justice, 1991.

[20] Economic Analysis of the Medical Malpractice System, the Rand Corporation, 1983.

[21] Brennan, Troyen, et.al., "Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I," New England Journal of Medicine 324:370-6, 1991.

[22] "Reporters' Study on Enterprise Responsibility for Personal Injury," Approaches to Legal and Institutional Change, Volume II, The American Law Institute, 1991 ("...the views in the Reporters' Study have not been considered by the membership and do not represent the position of the Institute...").

receive compensation through the legal system. If any changes are made to the malpractice system, therefore, the modifications should seek to open up the system to more claims, not to make it even more difficult to bring successful lawsuits.

Juries are not biased toward plaintiffs, and jury awards are not excessive.

Supporters of placing caps on damage awards and other limits on the malpractice system often claim that these reforms are necessary because juries tend to award high verdicts to sympathetic plaintiffs. Once again, the evidence shows otherwise.

Duke University Law School's Medical Malpractice Project recently completed a study which attempted to review every malpractice suit filed in North Carolina between July 1, 1984 and June 30, 1987 -- 895 cases. The project also collected information on more than 300 other cases filed in a sample of North Carolina counties between July, 1987 and December, 1990. The study found that medical malpractice juries are not consistently pro-plaintiff, nor do they award excessive damages.[23]

According to the study, about 40 percent of the cases reviewed were terminated without any payment to the plaintiff, and about 50 percent were settled. Only about 10 percent of the cases, or 117 cases, were decided by a jury.

Out of the 117 cases that went to trial, there were only four large jury awards, ranging in size from $750,000 to $3.5 million (subsequently reduced to $2.9 million). These judgments were awarded in cases involving severe brain damage, permanent paralysis and brain damage, death from suffocation by an intubation tube improperly placed, and a child who suffered brain damage at birth. The study found that the average damage award in cases that plaintiffs won was $367,737. But this number was much inflated by the four large awards discussed above. The median or mid-point award, on the other hand, was only $36,500.

The Duke study also found that juries are not biased in favor of injured patients. In the cases that went before a jury, the plaintiff prevailed in just one out of five. Furthermore, the juries found in favor of defendants in 18 out of 19 cases that insurers expected to win, and 13 out of 17 cases that insurers rated as questionable. And juries even ruled against plaintiffs in a majority of cases -- six out of 11 -- that insurers thought they would lose.[24]

A group of researchers evaluated over 8,000 medical malpractice cases filed in New Jersey between 1977 and 1992 and made a similar finding: "unjustified payments in medical malpractice cases are probably uncommon."[25] The study found that, out of the 976 cases that went to trial, plaintiffs prevailed only 24 percent of the time. Furthermore, payments were made in 91 percent of the cases where the doctor's conduct was deemed indefensible by the insurance company, and in 59 percent of the cases where the conduct was deemed unclear. Plaintiffs received payment in only 21 percent of the cases where the insurers deemed the doctor's behavior defensible. But the authors of the study noted that some of those payments were also justified, because evidence of the doctor's mistakes came out during the course of the case, after the insurance company had reviewed it.

Other studies have come to similar conclusions. A U.S. General Accounting Office study found that the median malpractice payment in 1984 was $18,000, and that 69 percent of victims

[23] "The Unfair Criticism of Medical Malpractice Juries," Neil Vidmar, Judicature, October/November, 1992.

[24] "Still Warring Over Medical Malpractice," Kenneth Jost, ABA Journal, May, 1993.

[25] "The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims," Taragin, MD, MPH, Mark I., et.al., Annals of Internal Medicine, 1992;117:780-784.

received less than $50,000.[26] Furthermore, the study found that any increases in settlements could be attributed to the rise in health care costs. According to the report, between 1981 and 1984, the average malpractice verdict increased at an annual rate of 3.9 percent, yet health care costs increased 11.8 percent.

In summary, malpractice insurance premiums represent less than one percent of the nation's health care bill. Fewer than ten percent of malpractice victims ever even bring a liability claim to recover their losses, and only a fraction of these claims are successful. Furthermore, jury awards and settlements in malpractice cases are not excessive, are not increasing at a high rate, and juries generally find for defendants when physician's care has met expected standards.

Finally, it has been estimated that the malpractice system helps **reduce** malpractice costs by about 10 percent because of the incentives in the system that prevent malpractice from occurring.[27] Therefore, restricting the medical malpractice system could increase overall costs by reducing these incentives and increasing the incidence of malpractice. And it must be remembered that placing limits on victims' rights to recover from negligent doctors will not eliminate those costs. Restricting victims' legal rights will merely redistribute the costs of malpractice to innocent parties.

DEFENSIVE MEDICINE

"Defensive medicine" has never been objectively defined or quantified, and its causes have not been identified.

Advocates of limiting victims' rights to sue argue that it is not just insurance premiums that make the medical malpractice system expensive. They claim that "defensive medicine" -- medical practices that are not in the best interest of the patient, but are performed to avoid liability -- is driving up health care costs. But so far, no one has been able to adequately measure the amount of "defensive medicine" that exists, nor to precisely identify its cause. So-called "defensive medicine" may simply be good, careful medicine. In addition, much care labeled "defensive medicine" may be the result of physician self-dealing -- profitable referrals for testing at facilities in which the doctor has a financial stake.

According to a recent study released by the National Liability Reform Coalition, a group backed by the AMA and other medical groups, "comprehensive" restrictions on the rights of medical malpractice victims will save only between $4 and $9 billion per year. If you add those savings to malpractice premiums, at most, limiting the malpractice system would save between $9 and $14 billion per year -- or between 1.125 percent and 1.75 percent of total health care costs.[28]

But more important, the Coalition-backed study admits that their defensive medicine numbers are based on assumptions about the causes and prevalence of defensive medicine and about physician behavior that have not been proven. The report states in the conclusion:

> "...defensive medicine is a difficult concept to define. There are a variety of reasons why a physician might perform services that are not warranted, including financial incentives, patient expectations, and lack of current clinical information. The wide range of potential motives, which are also likely to overlap in many cases, make it virtually impossible to isolate the contribution of defensive medicine costs."

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[26] U.S. General Accounting Office, Medical Malpractice: Characteristics of Claims Closed in 1984, April, 1989.

[27] Hofflander, Alfred E. and Nye, Blaine R., "Medical Malpractice in Pennsylvania," Management Analysis Center, Inc., 1985, p.xxiii.

[28] "Estimating the Costs of Defensive Medicine," Lewin-VHI, Inc., January 27, 1993.

In an earlier study using physician surveys, the American Medical Association estimated that "defensive medicine" cost $20 billion in 1988. The Physician Payment Review Commission has refuted this and other figures, however, saying, "Studies that use physicians' estimates of the amount of defensive medicine they practice are not sufficiently reliable to make quantitative estimates."[29]

One reason it is so difficult to quantify the costs of "defensive medicine" is that there is no single definition of the term. Depending on the definition, "defensive medicine" may actually be better medicine. Measures that physicians take in response to the threat of malpractice include: telling patients more about risks, keeping better patient records, obtaining more consultations, taking better initial histories from patients, scheduling more followup visits, providing more preventive services, studying the professional literature more regularly, attending more continuing medical education courses and improving communication with their patients.[30] Certainly these practices could improve the quality of care and thereby reduce negligence and injury. And preventing costly injuries saves the health care system money.

Determining the cause of "defensive medicine" has proved equally elusive. We have found no empirical evidence that the liability system is responsible for a substantial amount of costly or unnecessary medical practices. Two studies from 1991 indicate that these kinds of practices are caused by a very different motivation -- the profit motive.

A 1991 study by the state of Florida found that physicians in that state own the vast majority of certain health care facilities, and that these ownership arrangements have led doctors to order unnecessary tests and questionable treatments in order to increase their profits.[31] The report, commissioned by the Florida Health Care Cost Containment Board, found that at least 40 percent of the practicing doctors in the state have invested in facilities to which they can refer patients. In the case of diagnostic-imaging centers, the study found that doctors own 93 percent of such facilities. In addition, the study reported that the number of tests per patient is almost twice as great in doctor-owned labs than in those not owned by doctors. Likewise, the average per patient charge in a joint venture facility was more than twice the charge in a non-joint venture lab.

The Consumer Federation of America reported similar findings in their study of doctor ownership of diagnostic testing facilities. The report concluded, "The rapid spread of physician ownership of diagnostic testing facilities is a much more likely cause of rising diagnostic costs than defensive medicine."[32] The report found that physicians own or have compensation arrangements with one-third to one-half of all clinical laboratories. In the field of Magnetic Imaging Centers, physician ownership was found to exceed 50 percent. The study also reported:

* Compared to tests ordered at independent labs, self-dealing physicians ordered 34 to 96 percent more tests;

* Prices are 2 to 38 percent higher at physician-owned labs than at independent labs;

* The total bill was 25 to 125 percent higher for physician-owned labs.

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[29] Physician Payment Review Commission, Annual Report to Congress, 1991.

[30] Physician Payment Review Commission, Annual Report to Congress, 1991.

[31] Suplee, Curt, "Florida Reviews Ownership of Clinics," The Washington Post, August 9, 1991.

[32] Cooper, Mark N., "Physician Self-Dealing for Diagnostic Tests in the 1980s: Defensive Medicine vs. Offensive Profits," Consumer Federation of America, October, 1991.

Before victims are forced to give up their legal rights in the name of reducing so-called "defensive medicine," the economic incentives inherent in joint venture medical facilities owned by doctors must be reduced or eliminated. Until the profit motive is removed from such medical practices, controlling the prevalence of unnecessary and expensive medical procedures will be impossible.

Finally, if it were the case that limiting victims' rights would reduce defensive medicine, thereby lowering health care costs, then states that have restrictive medical malpractice laws would have lower health care costs. There is no evidence, however, that that is the case. For example, in 1976, California passed a medical malpractice law that is often cited by the AMA as a model for federal action. **Yet in 1990, California had the second highest per capita health care costs in the nation.**[33]

The Congressional Budget Office made a similar finding in testimony before this committee in 1992.[34] The testimony concluded:

> "Moreover, if the system of medical malpractice liability were modified, the resulting change in national health expenditures would be uncertain, and, if any reductions occurred, their magnitude would probably be small. In fact, much of the care that is commonly dubbed "defensive medicine" would probably continue to be provided for reasons other than concerns about malpractice. Finally, any reductions generated by a different malpractice system might be offset by an increase in other medical services -- including high-risk ones -- either for therapeutic reasons or as a reponse to reductions in physicians' income."

The Office of Technology Assessment is currently conducting a study of defensive medicine that should be concluded next year. Given the dearth of other reliable information on "defensive medicine," it would be premature, at best, to pass legislation aimed at this problem before the OTA has issued its report.

CAPS ON PAIN AND SUFFERING DAMAGES

Capping pain and suffering discriminates against injured women, children, and senior citizens.

One of the most frequently cited malpractice "reforms" is placing a cap on "pain and suffering" damages of malpractice victims. The cap is usually set at about $250,000. This proposal would affect only the most unfortunate victims -- those who are permanently or catastrophically injured by doctor negligence -- since only the most seriously injured individuals ever receive over $250,000 in pain and suffering awards. What is worse, studies show that even under laws that contain no limitations on damages, the most seriously injured victims are undercompensated by the legal system.[35]

Furthermore, it is misguided to separate pain and suffering damages from other types of damages. Compensation for pain and suffering is compensation for real loss and should be treated in the same way as damages for out-of-pocket expenses. For example, a woman who loses her ability to ever bear children, a child whose childhood is stolen away because of prolonged illness or injury, or parents who lose their children, all suffer losses that deserve compensation, even if the loss does not result in a direct financial expense. Moreover, placing

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[33] "Health Care Spending; Nonpolicy Factors Account for Most State Differences," General Accounting Office, February, 1992.

[34] CBO Testimony, Statement of Robert D. Reischauer, Director, Congressional Budget Office, before the Committee on Ways and Means, U.S. House of Representatives, March 4, 1992.

[35] U.S. General Accounting Office, Product Liability: Verdicts and Case Resolution in Five States, 1989.

limits on pain and suffering damages has discriminatory results because it targets a very specific population -- non-wage earners. In other words, those most affected by this proposal would be women, children and the elderly. Even if this proposal would result in lower malpractice premiums, do we really want to cure the ills of the insurance system on the backs of this vulnerable population?

DON'T LIMIT VICTIMS' RIGHTS, LIMIT NEGLIGENCE

Far too many innocent people are injured or killed every year due to medical malpractice. The liability system is designed to compensate the victims of medical negligence and to deter physicians from negligent behavior. The malpractice system is not perfect -- too few victims are able to recover through the courts and the incidence of malpractice continues at an unacceptably high rate. Therefore, attempts to lower the cost of health care by limiting victims rights in medical malpractice would be both misguided and cruel. The Physician Payment Review Commission concluded in its 1991 report to Congress that:

> "...tort reforms tried to date are unlikely to improve significantly the malpractice system's performance...Tort reform is generally geared toward excluding claims rather than including in the system the many negligent injuries that presently do not result in claims. Neither deterrence nor defensive medicine is likely to be much affected by tort reform."[36]

The only humane and effective mechanism for lowering medical malpractice costs is to limit the incidence of physician negligence and thereby lower the number of malpractice victims.

RECOMMENDATIONS

Rather than limit victims' rights, Public Citizen urges that the following reforms be implemented on the state and national levels to reduce medical malpractice and improve the quality of health care in this country:

1. Better doctor discipline is essential to reducing the incidence of medical negligence. Because a small number of doctors cause the most malpractice, removing incompetent providers from practice will lower needless injuries and deaths resulting from negligent care.

** States should give licensing boards more power to discipline physicians, including emergency suspensions pending formal hearings in cases where a doctor poses a potential danger. In addition, medical board decisions should take effect while being appealed through the court system.

** State boards should be restructured to ensure strong consumer representation and loosen ties with medical societies.

** Adequate resources should be provided to the boards to ensure timely and thorough investigations of complaints. One hundred percent of license fees should go to funding the boards. In addition, Congress should create a small program of grants-in-aid to state medical boards. The grants should be tied to the boards' agreements to meet certain performance standards.

** Consumers must have increased access to information on physicians' medical malpractice history. The National Practitioner Data Bank that holds information about actions taken against negligent doctors should be open to the public. In additon, the Drug Enforcement Agency should release a monthly list of all practitioners whose controlled substances prescription licenses have been suspended.

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[36] Physician Payment Review Commission: Annual Report to Congress, 1991, p.382.

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** Insurance companies should forward all claiming and settlement information on physicians to state licensing boards.

2. <u>Insurance reform would ensure sensible underwriting and thereby lower costs in the health care system.</u>

** Insurance companies should be required to better spread risk by placing all physicians in a unified pool. Currently, the sub-categories used by insurance companies result in sky-high premiums for certain specialties.

** In order to differentiate "high-risk" doctors, insurance companies should charge rates based on a physician's experience. This would ensure that doctors with histories of negligent behavior would pay more.

3. <u>Improved physician training and oversight would limit negligent behaviour, and the resulting costly injuries.</u>

** Risk management programs should be implemented to decrease medical negligence.

** Physician recertification should be implemented, requiring written examinations, and audits of medical performance through a review of patient records.

** Practice guidelines should be developed for certain procedures. A 1989 Harvard Medical School study found that practice guidelines for anesthesia have drastically reduced the incidence of death or brain damage to patients. The study also found a dramatic drop in the cost of medical malpractice premiums for anesthesiologists.

** Physicians who are aware of other doctors' incompetence should be encouraged through confidentiality and immunity to report negligence to the appropriate disciplinary body.

4. <u>Voluntary alternative dispute resolution mechanisms should be established to enable medical malpractice victims with small claims to seek compensation through a streamlined system.</u>

Finally, the U.S. should adopt a single-payer national health program modeled on the Canadian system. This sensible step could provide our country's residents with universal and adequate health care at the same cost as the current system, which has failed a large segment of society. A universal health program would also have the effect of reducing the numbers of malpractice lawsuits, because injured victims would not need to turn to the legal system to be compensated for their health care expenses. Those expenses would simply be paid for through the public plan.

Public Citizen will continue to work towards the goal of universal health care. Likewise, we are committed to working strenuously to defeat any measures that would make it even more difficult for victims of medical malpractice to recover from wrongdoers. Thank you.

[A COPY OF THE REPORT, "COMPARING STATE MEDICAL BOARDS," PREPARED BY PUBLIC CITIZEN'S HEALTH RESEARCH GROUP, IS BEING RETAINED IN THE COMMITTEE FILES.]

Chairman STARK. Thank you.

Dr. Rubin, if in fact there are to be savings in the area of defensive medicine, why can't we find any reduction in the use of those highest cost areas like MRI, CAT scans, things like that in California where we have about as good tort reform as we will ever see? Why doesn't the reaction of the medical community indicate any reduction in the use of those kinds of things?

Dr. RUBIN. Well, speaking as a physician, let me say that the issue here is a threshold one. It is not the amount for which I would be sued. I must knock on wood and say that in the 23 years that I have been practicing medicine, I have yet to be sued. This may or may not be because I don't practice as actively now as I did earlier. At any rate, the issue here is that I want some assurance that I am not going to be sued at all.

Indeed, the tort reforms that you spoke of, both in California and other places, don't necessarily assure that physicians will not be sued. What they do assure is things such as limits on payments. So, I am not surprised that there is not a reduction in some of the procedures that you talked about.

Chairman STARK. Do you really think that the doctors in the world feel that that is what they want? When they talk about malpractice reform, they want insulation from basically ever being sued?

Dr. RUBIN. No. Well, I can't speak for all physicians. We had somebody from the AMA that at least spoke for a substantial number of them.

My view is that to the degree that defensive medicine is practiced, it is done as a way to—at least physicians believe—to keep from ever being sued. I think that things that will keep physicians from being sued are successful in reducing certain kinds of behavior.

I think the example in Maine, where physicians are given immunity from suit if they follow certain guidelines, is very compelling evidence. As we point out in our study and as I said in my oral remarks, relative to the use of x rays of the spine following trauma, x rays were done virtually 100 percent of the time in the emergency room. Following this new program in Maine, it has now been cut in half, and I believe that much of this is due to the fact that you can get immunity. So, I think that, yes, immunity is a very important determinant.

Chairman STARK. So your answer is, if I understand it, the reason we didn't see any reduction in the number of costs of procedures in California is because the tort reform wasn't sufficient?

In other words, it is still you are in for a dime, you are in for a dollar. If it is a $250,000 cap, that is still a big enough worry and the premiums are a big enough worry so the marginal differences weren't worth it.

Dr. RUBIN. That is particularly true. Let me say that I don't have any direct knowledge of whether the usage of those procedures did or didn't decline after the tort reform. We did not look at this on a State-by-State basis. But, assuming your conditions, my answer was appropriately summarized by the Chair.

Chairman STARK. Could I then extrapolate from that the following, that in your opinion mild caps won't do the trick in terms of

changing practice. I am not suggesting that practice patterns and more research may not do it, but if you just take the change in either premiums or tort limitations, unless there is a substantial change in the risk, we are apt not to see much change in behavior on the part of physicians; is that fair?

Dr. RUBIN. I think that over time some of the widespread and comprehensive pieces of tort reform may well show a reduction. But, I think that a much greater reduction would occur, as we point out in our study, in a situation where physicians would not be at risk of suit.

Chairman STARK. Let me ask you this, as a physician—and you have heard the testimony today on this issue of enterprise liability, which I must admit confuses me. I can't figure who is pushing it and why, but my paranoia runs high and I figure somebody is in it for the money and not for the good of the public.

How would you say that a doctor would respond to the idea that regardless of what enterprise the doctor was connected with, let's just say he were a member of Aetna's preferred providers and that was sufficient enough so you couldn't be sued, but Aetna preferred provider could, that would in effect be almost the same as taking all the worries of personal liability off your shoulders, wouldn't it?

Dr. RUBIN. Well, first of all, I share your confusion as to exactly what enterprise liability is. However, as I understand it, you are right. You, as a physician, would not be sued.

The issue is what Aetna would then do with a physician who was sued, particularly since we know that suits are frequently brought for bad outcomes rather than bad decisions. I think that this is really the central issue for me, as a physician, in deciding whether or not enterprise liability is a good or a bad idea. I just don't know enough about it at this point.

Chairman STARK. Is it fair to say that there is a bit of uncertainty in a 5-year savings range that runs somewhere between $7 and $70 billion.

Dr. RUBIN. Mr. Chairman, I am glad you brought that up. I heard you mention that to the gentleman from the GAO earlier this morning. I think that I would like to have the opportunity to explain it.

Chairman STARK. Go ahead.

Dr. RUBIN. Basically what we used to formulate our estimate, as I said our midrange estimate was $4.3 billion in 1991 dollars, is a technique called sensitivity analysis. In other words, we really wanted to let people make their own assumptions.

So, we started by saying that there was a baseline of, in essence, $15.1 billion in 1987 of costs in excess of premiums. We then performed a variety of calculations and obtained a number that represented $29.7 billion in the current year.

We said, you can believe that of this cost in excess of premiums, defensive medicine represents either 20 percent, 40 percent, or 60 percent. Being somewhat conservative, we used the 40 percent estimate, which reduced the cost to $11.9 billion.

We then said that there are a variety of reforms that can take place. Indeed, we said that one of them is the use of guidelines, which we didn't think would have a very big effect on cost savings, only 25 percent. A comprehensive tort reform package, modeled

quite frankly, after Mrs. Johnson's bill, we thought would have a 60 percent effect. And, the most far ranging reform of all, which was the introduction of no-fault, we thought would result in an 85 percent reduction in the cost of defensive medicine.

So if you multiply the $11.9 billion by 0.6 you get $7.1 billion. We then said that although doctors are stubborn and all of the savings cannot be obtained in 1 year, you might get at least 60 percent in 1 year. So if you multiply the $7.1 billion by 0.6 you get $4.3 billion.

Now, others can be more optimistic about physicians' abilities to respond to the right stimuli. Others can say that more of the costs in excess of premium were a result of defensive medicine. We then said, take a look at $4.3 billion, and decide whether it is reasonable relative to some clinical things we know.

We looked at Caesarian sections, which most believe are a problem. There was an article in the Journal of the American Medical Association approximately 1 month ago that showed a correlation between the rate of Caesarian section and the rate of malpractice suits.

We then made some estimates, and the CDC made some estimates and said, gee, if we only got down to the level recommended by their experts in Health in the Year 2000, we could save over $1 billion. So we chalked up $1 billion.

A peer review article in the literature suggested 60 percent of presurgery testing is unnecessary. The testing is unnecessary not for the reasons that Ms. Gilbert mentioned, but because anesthesiologists, who order these tests, receive no financial remuneration from the tests. So, we thought if this was something that people were aware——

Chairman STARK. Do you have a——

Dr. RUBIN. Let me finish. That is 2.7 billion and another one is 150 million and——

Chairman STARK. Let's talk about the 4 billion. Do you have a plug figure for what part of that 4 billion is administrative?

Dr. RUBIN. No.

Chairman STARK. So mostly that is savings on procedures. Is that correct?

Dr. RUBIN. That is correct.

Chairman STARK. Now, are you familiar with the studies in the system of cost shifting?

Dr. RUBIN. Yes, I am.

Chairman STARK. All right. Do you believe it goes on?

Dr. RUBIN. Yes.

Chairman STARK. What are we then saved? You are going to cut $4 billion out of some tests that an internist is going to order for the radiologist and the radiologist will just jack up the price of his other tests to make up for the $4 billion you cut out of his tests and the universe hasn't saved a damned dime.

Dr. RUBIN. Oh, but I think the whole issue——

Chairman STARK. Or will cost shifting not exist for savings in malpractice or only for savings in Medicare?

Dr. RUBIN. No. I think the issue is, first of all, you are defining unnecessary tests to be taken out of the system using our defini-

tion. I think that there clearly needs to be other things as part, as we pointed out, as part of the comprehensive reform——

Chairman STARK. That isn't before us. We are just talking because we don't know what is happening. With any kind of cost control, there is no reason why the economy should save a dime, is there?

Dr. RUBIN. Certainly. If you are taking out 4.3 billion dollars' worth of tests.

Chairman STARK. Right.

Dr. RUBIN. That is money that is irrevocably gone.

Chairman STARK. All you have to do is raise the price of other tests. You told me there is cost shifting and so did the GAO. It is almost all of the cuts we make in payments are picked up at cost shifting.

Dr. RUBIN. But there is cost shifting because the Federal beneficiaries pay substantially less than costs.

Chairman STARK. You don't think these guys are going to cost shift any time you cut into their gross income?

Dr. RUBIN. Well, if this is done system-wide, and——

Chairman STARK. And it is.

Dr. RUBIN. As I said, then there is no one to——

Chairman STARK. No savings is there.

Dr. RUBIN. There is nobody to cost shift to, number one.

Chairman STARK. Why not? There are still going to be some tests that are required. You are a radiologist, let's say, and 30 percent of your business is from unnecessary tests caused by defensive medicine and you have to make your Porsche payment and send the kid to Harvard. You are going to cut out 30 percent of your tests. What do you do? What every other doctor does, you raise the price of the other tests, don't you?

Dr. RUBIN. If one believes that that is the case.

Chairman STARK. Don't you believe that is the case now?

Dr. RUBIN. Not uniformly in the kind of system that we are talking about.

Chairman STARK. I am talking about the system that exists today. Do you not believe there is cost shifting?

Dr. RUBIN. I believe that there is cost shifting, to a degree, as a result of Federal payments below cost.

Chairman STARK. Why is it not payments from PPOs? You think they don't shift costs when a managed care group rachets down?

Dr. RUBIN. Well, Mr. Stark, in order to shift costs, you have to have a shifter and shiftee.

Chairman STARK. That is right. So the same radiologist who loses the chance to do the MRI shifts those costs to those tests which are still required.

Dr. RUBIN. With the growth in managed care organizations, there are going to be radiologists who lower their prices and say why go there when this person has raised his prices, to use your phrase, to make his Porsche payments. Why not come to us?

I think there will be savings. Do I think it is going to be 100 percent? No.

Chairman STARK. You have an interesting concept of cost shifting in that you think these guys are bright enough to tell which is a Federal dollar coming through their building and which isn't.

So if it is a reduction in price by Aetna, I am not going to shift the cost, but if it is a reduction of price through the intermediary, I am. You ascribe to your colleagues a level of economic sophistication which I question.

The fact is that cost shifting goes on. We have a brand new CBO report, and I can't believe there is a medical economist in the country who doesn't recognize cost shifting. So you take $4 billion out, which is a pittance, but these guys will pick it up and shift it to somebody else. What have we saved? If in fact there is cost shifting, we have saved nothing; is that not correct?

Dr. RUBIN. If the $4.3 billion is shifted someplace else, that is correct.

Chairman STARK. So I go to Ms. Gilbert and say, Ms. Gilbert, all we have done is deny the poor consumer the chance to get a reasonable break because you can't put the guys in jail. Mr. Beckham just told me that is not right. I can't get all them in there with Ivan Boesky to study tennis. I have to let them go. Without the right to sue people, how do we get the doctors to behave?

Ms. GILBERT. That is exactly right. In fact, I read a letter to New York magazine recently, unfortunately unsigned, by a physician who had been malpracticed upon when she was giving birth and her baby was very severely brain damaged. And she herself is a physician. She ended the letter by saying, "If you take away my right to sue, you had better give me right to shoot." And there is a lot of truth there.

A lot of what gets lost in this debate is justice and fairness and that people who have been wronged want a forum in which to go and prove that they have been wronged and then to receive their just compensation. And that is what our court system is there for, and if you take away all the rhetoric, it is really not used all that often. It is used by a very small percentage of injured victims, but when they choose to use the court system, it really shouldn't be curbed except for a very, very good strong reason.

And as you can see from the numbers that have been bandied about today, the savings, if any, in restricting victims rights are very soft and they are small. Even those soft numbers are small.

I am prepared to accept Mr. Rubin's numbers, even though I don't agree with them. If you accept those numbers and add them to malpractice insurance premiums and assume that you eliminate all of that from the system, you are still talking about 1 percent of health care costs. And I would hasten to add that we believe there is a strong deterrent effect in the system, in the malpractice system, so that you may add to health care costs by reducing malpractice victims' rights because you will take away the incentive to practice safe medicine, and negligent medical care jacks up our health care costs significantly.

Chairman STARK. You are a lobbyist, you said, so you must be aware of some of the politics. There is some kind of a movement afoot by a group I am having trouble identifying to kind of just do away with major tort claims in general. I suspect it is like the tobacco companies and manufacturers of dangerous products like automobiles who have had some bad experience in being forced to do what is right in court when they wouldn't do it otherwise.

But it is interesting to me that when it comes to intellectual property, I am unaware of any of the pharmaceutical companies or any of the new software manufacturers complaining about excessive awards in the area of intellectual property. Have you heard of anybody complaining about that?

Ms. GILBERT. No. That is a very good point.

Chairman STARK. I am aware these same pharmaceuticals would slaughter half of the people in Brazil before they would let them manufacture under their patent. I am very upset about some woman who may have some malformed child suing the same pharmaceutical company, and that is where they want a tort limit. I see a distinct pattern.

Are you familiar with that kind of thing going on where major companies, whose arrogance and transgressions against the defenseless consumer have been well chronicled by your founder, that suddenly they get very righteous and indignant about all the costs to our economy of these frivolous suits. Yet when they are suing one another, it is no holds barred. How do you reconcile that difference, that double standard?

Ms. GILBERT. Well, you exactly identified the double standard. And if you look at the numbers in court filings, the fastest rising court filings are contract disputes. It is corporations suing each other. Real property disputes. Bankruptcy.

Chairman STARK. Can I give you one a little bit of testimony we had once not so long ago. Guess who are the biggest users by half, more than all of the other people combined of collection attorneys? Guess who uses collection attorneys more than any other group in the country combined? I don't want to lead you. Just guess. Would you guess it was doctors or hospitals?

Ms. GILBERT. Either one.

Chairman STARK. More lawsuits for collection are brought by doctors and hospitals than any other group of people combined in this country. So when it comes to suing the patient, to provide the money, they don't wait a minute. But when it comes to the reverse, they are in here pleading poverty and crying all over the place. Very interesting.

Thank you for your testimony.

Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

In view of the hour, I want to go to a few questions to Dr. Rubin.

Dr. Rubin, do you have any information on how CBO would score malpractice liability tort reform in terms of savings to the health care system?

Dr. RUBIN. My understanding is that CBO will probably not score any savings because they believe, at least the last time we spoke, that there are behavioral changes that are required of physicians and they are unsure of the possible magnitude of these changes. They also subscribe to the point, made earlier by the Chair, that physicians will do other things to preserve their incomes.

I think that the head of the CBO, Mr. Reischauer concurs with the methodology of our study. Indeed, as he expressed in a letter to me, Mr. Reischauer agrees with our monetary findings and says

that they are substantially the same as his and the CBO's. That is my understanding of his position. Perhaps CBO can explain why.

Mrs. JOHNSON. What I understand you saying is that CBO agrees that your methodology is correct and the savings you project are correct.

Dr. RUBIN. Yes.

Mrs. JOHNSON. And agree there will be behavioral changes that will offset those savings.

Dr. RUBIN. That is correct.

Mrs. JOHNSON. So then it is a question of whether one believes we can affect the system in such a way that those behavioral changes won't take place, and I personally believe there are ways that we can prevent those changes from taking place.

Dr. RUBIN. I would agree, and I thought that that was part of why we were doing health care reform.

Mrs. JOHNSON. I don't think you can look at any one of these changes in isolation. They are a part of a series of the changes, and if the rest of changes aren't made, then, of course we leave that possibility open. But if we make the rest of the changes, then there won't be that opportunity and I think that is the challenge to us.

You are doing some very interesting work in overseeing or in studying what is going on in Maine. Could you enlarge on that a little bit and also talk a little bit about how you see that going in the future?

Dr. RUBIN. Well, we will be looking at Maine and some other States. But, particularly in Maine, because of the concept of immunity following the 22 guidelines that have been laid out, to see whether defensive medical practices really are reduced. And, we are just beginning. But the Wall Street Journal, as you probably know, has reported a substantial diminution in the use of those procedures covered by the 22 guidelines.

We would also like to look at some other States that have taken a different tack. The Chair has several times mentioned, as has Mr. Thomas, California. We would like to look there, too, and hopefully answer the question that the Chair asked earlier: Has there been a change when one carefully looks at some of these procedures?

Mrs. JOHNSON. But the suggestion, the conclusion that Maine at this point suggests is that if physicians are allowed to practice medicine in harmony with their training and common sense, that they don't do as much testing when they think they aren't going to be sued.

Dr. RUBIN. That is correct.

Mrs. JOHNSON. Some would say that your definition of defensive medicine for your study was very, very conservative. I was impressed by your testimony where it says, "We define defensive medicine as changes in practice carried out for the sole purpose of avoiding malpractice claims." That is a very, very conservative definition. I think it was a wise definition, but could you talk a little bit more about how you define "sole"?

Dr. RUBIN. Well, we defined it as tests that the medical establishment views as unnecessary and that have no possible benefit to the patient. We realize that there is always the odd chance that

there might be a de minimis positive effect, so we included that in our definition.

But in trying to sort that out, the examples that I gave, for example, presurgical testing, a group has concluded that 60 percent of these are totally unnecessary. The people that order these tests have absolutely no financial gain. The anesthesiologist does not make 1 penny more whether he orders the tests or not, because they are performed by the hospital lab or an outside lab. So, we concluded that the only reason an anesthesiologist would order these kinds of tests would be to avoid malpractice. One of the authors of the study that we cite is chief of anesthesiology at a major medical school in the Midwest.

The same kind of situation exists with electronic fetal monitoring. There, we used the best judgments of obstetricians and gynecologists. The same would hold true for the skull x rays that we used.

Obviously, one needs to look at the panoply of medical practice if one is going to do this on a systematic basis. But, it seems clear to us that, as Ms. Gilbert and others have pointed out—and we want to thank her for quoting our study—it is very difficult to discern whether somebody practices defensive medicine only to avoid medical malpractice or to incur financial gain. That is why we maintained a very narrow focus.

We felt that cost of excess premiums to be attributed to defensive medicine was only 40 percent, rather than some of the higher numbers that were used before.

Mrs. JOHNSON. I think that is very interesting about this study. It is a very conservative definition of what is a defensive cost. It is also well documented, the few specific procedures that you took, and therefore it is an indication that over $4 billion a year could be saved is a very significant indicator, very significant conclusion.

We had an exchange on that with the preceding witnesses about things are only 1 percent of the pie. Nothing is very much of the pie. Health care reform to control costs is going to have to control costs in every way it responsibly can, and if it can cut the premiums of malpractice, if it can eliminate things that even the medical community has come to view as unnecessary, all of that is, in my estimation, in the public interest.

And I think the examples that you give reflect a period in which they developed a lot of protocols that have now come to be accepted procedures and they are not thought about any more, and your study is based on physicians thinking about them and looking at whether there is any benefit to the patient and I think that makes it a very valuable study to us.

Also, I just want to mention that one of the real virtues of malpractice, Ms. Gilbert, I think that your comments reflect a recognition of this and this whole hearing has mentioned this in many ways, one of the enormous benefits of malpractice reform is it is going to create a far greater number of cases. At first, there is going to be a huge number of cases because all of those little cases that don't have big money attached to them and can't afford lawyers and are afraid of the legal system will come forward and I would maintain that that would give us the power to get at some

of the problems that are causing negligent behavior or causing bad outcomes far earlier in the system.

If you look at all the people now who never get into the system, and the Harvard study showed how many, what a huge proportion of elderly cases never get any attention because they are not going to be big dollar awards, they are not a very big deal, they are just a big deal to the little person who got hurt.

So that while in your testimony, Ms. Gilbert, you point out that reform would penalize vulnerable members of our society, failure to reform is keeping the majority of middle income and low income Americans out of the system. And one of my hopes is that if we can reform the system so that more people have access, we will actually have far more knowledge of what is creating bad outcomes in our medical process, our medical care community and we will be able to catch practitioners at that point in their practice where they are creating small problems and not as so often happens wait until they have created a very big problem that is going to leave somebody lifelong damaged.

So one of the things as we all go forward in this I think to keep in mind is that our current system isn't giving us the knowledge to improve it, nor is it serving the majority of Americans.

Thank you for your really very good testimony on both your parts, and I appreciate your staying so long.

Ms. GILBERT. Could I just respond to that. Because I couldn't agree with you more that real reform of the system would invite many, many more people into some kind of system for compensation who aren't in the system today. It is listed in our recommendations that we should set up alternatives for people with quote, "small claims."

As you point out, a small claim in the malpractice system is a very large claim to an individual, yet they are shut out because they can't afford to get a lawyer, to go to court on such small damages, and we are wholeheartedly in support of a system like that. However, I think that is contradictory to the kinds of debate that went on today about reducing costs in the system.

If the reform is aimed at reducing costs in the malpractice system, that is not consistent with bringing more people into the system. I think it would be very positive to bring more people into the malpractice system. I don't think you are going to reduce costs that way. I personally don't think that is a problem.

I think we need to reduce costs in the health care system by reducing administrative costs and you can get about $90 billion of savings that way, but not through the $4 billion that you could perhaps get in the malpractice system at the expense of very seriously injured people.

So reform means many different things to many different people. If it means expanding the system, we support it. If it means capping the damages of the most catastrophically injured victims, we would oppose it.

Mrs. JOHNSON. I appreciate that. I think one can legitimately support opening up the system and still believe that the evidence that we have gained through those States that have capped punitive damages that really go to a very small number and do seem

to save money on premiums and do seem to have some real benefits.

One could take both those positions, but I wonder do you support those parts of our proposals that would limit legal fees, that would limit contingency fees at least to a percentage of the awards so that as the award escalates, the lawyer's portions of that declines. So that when a person is clearly more seriously damaged, they get a larger percentage of award than someone for doing the same work, just because the award is larger, the lawyer doesn't get millions and millions more dollars or hundreds of thousands of more dollars?

Ms. GILBERT. In my work I have spoken to many, many victims who have brought malpractice cases as well as product liability cases and other lawsuits. I have never heard them complain about the amount of money their lawyer took from their award. I do, however, hear them complain vociferously about the person they are suing and the fact that they delay that case sometimes for years and years and years. Every time they want another document, they have to go back into court to litigate to get that document. It is pulling teeth to go through a lawsuit, generally, against these big corporations or large defense insurance firms.

And I will contend they are doing that partly because they are driving up their rates. They get paid by the hour. The longer they are there, the more money that those defense lawyers make.

That is where the money is getting wasted in the system. It is not the contingency fee. A lawyer in the medical malpractice business loses 80 percent of the time. Eighty percent of those cases, they get zero. So they have to make up for that in the 20 percent of the cases where they do get paid.

Mrs. JOHNSON. And that is interesting.

Dr. RUBIN. Sounds like cost shifting, wouldn't you say, Mr. Chairman?

Chairman STARK. It sure does.

Mrs. JOHNSON. Thank you, Ms. Gilbert, and thank you, Dr. Rubin.

Chairman STARK. I thank the panel and again apologize for the extended time. Thank you very much, Doctor.

This hearing is adjourned.

[Whereupon, at 2:56 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT

of the

AMERICAN ASSOCIATION OF BLOOD BANKS

to the

SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES

on

MEDICAL LIABILITY REFORM

June 3, 1993

Mr. Chairman and members of the Subcommittee:

My name is Arthur J. Silvergleid, MD. I am Medical Director and Executive Director of the Blood Bank of San Bernardino-Riverside Counties and President of the American Association of Blood Banks (AABB) On behalf of the AABB, I am pleased to have this opportunity to submit a statement regarding the unique liability concerns facing the providers of blood services and our need for medical liability reform.

As the subcommittee studies the current medical malpractice system in the context of over-all reform of the American health care system, the American Association of Blood Banks (AABB) urges you to enact comprehensive, nationwide medical liability reform which covers blood services. California's Medical Injury Compensation Recovery Act (MICRA) would serve as an excellent model for this reform. Whatever form of medical liability reform is chosen, the AABB urges Congress to draft this legislation so that the providers of blood services are clearly included.

SPECIFIC INCLUSION OF BLOOD SERVICES IN MEDICAL LIABILITY REFORM LEGISLATION WOULD AVOID COSTLY LITIGATION

The American Association of Blood Banks (AABB) is the professional medical society for approximately 2,400 community, regional and Red Cross blood centers, hospital-based blood banks and transfusion services and over 8,800 individuals engaged in blood banking and transfusion medicine. Our member facilities are responsible for collecting virtually all of the nation's blood supply and for transfusing more than 80 percent of the blood used for patient care in the United States.

The AABB is dedicated to maintaining a safe and adequate blood supply for the American people. However, in recent years our membership, which is virtually all non-profit, has been faced with expensive litigation arising from the period prior to 1985 when there was no laboratory test to screen blood for Human Immunodeficiency Virus (HIV), the virus that causes AIDS. While almost all of these lawsuits are dismissed pre-trial or won in court, the increased burden in time and other resources that this litigation has created for this component of the health care system has been staggering.

Since state legislators often do not specifically address whether blood services are entitled to the protection of state enacted medical liability reforms, this issue must be litigated on a state-by-state basis. Resolution usually involves complex legal arguments that result in lengthy appeals. The litigation costs for both sides are enormous. For this reason, we are urging the drafters of medical liability reform legislation to clearly include blood services among health care providers covered by liability reforms in order to avoid costly litigation on this issue.

BLOOD SERVICES ARE A PART OF MEDICINE

Including blood services in medical liability reform proposals would not only reduce litigation costs, it is good public policy. Blood services are performed by highly skilled and specialized medical professionals, including physicians, nurses, and allied health professionals. Hospitals and transfusion recipients rely on the medical skill and expertise of blood service providers in collecting, testing and processing of blood.

Procedures for screening and testing blood are inherently medical in nature and require strict adherence to the highest standards. Blood donors must be screened for possible health risks in determining whether or not to accept their donation. Once the blood is drawn, a number of specific medical procedures must be performed ranging from hematocrit and hemoglobin tests to sophisticated tests for hepatitis, HIV antibodies, and other evidence of infectious disease. These inherently medical procedures are performed in an attempt to insure that the unit is as safe for transfusion as is reasonably medically possible. Finally, a blood bank must "cross-match" the unit to determine whether it is compatible with that of the potential recipient.

The procedures performed by a blood bank utilize the latest developments in medical technology and require the exercise of medical judgment. Their medical services are performed for and are inherent in the medical care and treatment of the transfusion recipient. It is therefore natural to apply medical liability rules to the providers of blood services.

State and Federal laws and regulations govern virtually every aspect of the operation of blood banks. Blood centers are registered with or licensed by the FDA and subject to government inspections. Many blood centers are also inspected and accredited by the AABB. Blood service personnel must conform to stringent education and training standards. This regulation serves to maintain the professional standards of the facilities and individuals who provide blood services.

Most state courts have interpreted their medical liability reform statutes to apply to blood services. In California, where several transfusion AIDS lawsuits were consolidated to resolve common legal issues, the courts interpreted California's Medical Injury Compensation Recovery Act (MICRA) to apply to blood services. The California Supreme Court confirmed that because blood banks provide a service that is inextricably identified with human health, they are health dispensaries entitled to the liability protections provided by MICRA. However, where the law is not clear, plaintiffs still often argue that the providers of blood services are not covered by medical liability reforms such as MICRA.

AABB SUGGESTS FOCUSED DEFINITIONS IN REFORM LEGISLATION

Medical liability reform acts often limit their applicability to lawsuits involving "health care services" provided by "health care providers." These terms are defined to specify which services and entities are covered. To insure that blood services are covered, we recommend that medical liability reform legislation define these terms to include facilities and personnel that provide blood services.

For example, we suggest the following definitions:

HEALTH CARE PROVIDER.-- The term "Health Care Provider" means any individual, organization, or institution that is engaged in the delivery of health care services that is required by state or federal law or regulation to be licensed, registered, or certified to engage in the delivery of such services.

HEALTH CARE SERVICE.--The term "Health Care Service" means any service provided in connection with the diagnosis or treatment of a patient or donor, including the acquisition, preparation or transfusion of any human blood or blood components.

CONCLUSION

Specific language in national medical liability reform legislation is needed to clarify that Congress intends the legislation to be applied in lawsuits involving blood services. This would insure that uniform liability rules are applied in all medical malpractice lawsuits.

TESTIMONY OF AMERICAN DENTAL ASSOCIATION

The American Dental Association (ADA) is pleased to have the opportunity to present its views on the issues relating to professional liability and the need to reform the present malpractice system. The Association agrees with Chairman Stark that the current system is too costly and resolves claims in an inequitable manner. We believe that comprehensive reform of the professional liability system is necessary if the proper goals of such a system are to be accomplished.

The ADA believes that the profession should encourage programs that seek to reduce the incidence of negligent behavior. Toward this end, the Association has sponsored risk management programs, which have proven to be effective in educating practitioners to techniques and processes which minimize risk to patients and maximize the quality of care provided. While we, of course, will continue to stress the necessity of offering such programs, a risk management program is certainly no substitute for comprehensive reform.

Studies indicate that there may be a cyclical nature to the reduced availability or increased costs of liability insurance; however, there are systemic problems which exacerbate the situation and make it likely that another crisis is always "just around the corner".
In fact, information published in 1992 indicates that claim frequency is no longer declining and that there is a possible renewed acceleration in claim severity. Tort reform would bring a much higher degree of predictability to liability costs, significantly decreasing the frequency and severity of the cyclical changes and avoiding the large rate increases that can cause a crisis environment.

The current liability system is unfair to injured patients. Much of the money awarded to the relatively few patients who are compensated through the current tort system is absorbed by the system's overhead. The RAND Corporation has estimated that only 43% of money spent on liability litigation is received by the injured party. Other studies have estimated this figure could be as low as 30%.

In many instances patients wait for years to have their cases resolved. A 1987 General Accounting Office (GAO) study of claims closed in 1984 established that the average time from the filing of a claim to its disposition was approximately 25 months.

The current liability system does not serve patients, providers or the public well. Too often, competent practitioners are needlessly confronted with unfounded, yet costly, litigation. Also, the public is shortchanged by a system that adds to the cost of health care through increased professional liability premiums and defensive medicine.

To address the problems with the current liability system, the Association recommends a federal legislative initiative that incorporates the following provisions:

<u>Uniform Standards for Medical Liability Claims</u>

- Periodic payment of future damages over $100,000.
- $250,000 limit on non-economic damages.
- Mandatory offsets for collateral sources -- claimant receives credit for out-of-pocket expenses paid to acquire collateral source.
- Plaintiff's attorney fees limited by sliding scale.
- Proportionate liability among all parties -- each defendant is liable for the percentage of damages caused by that defendant.
- Expert affidavit -- any claim filed in court or an ADR proceeding must be accompanied by an affidavit from an individual qualified to be an expert witness asserting that the claim has merit.

<u>Alternative Dispute Resolution</u>

- Federal support of state demonstration projects to evaluate the merits of ADR proposals designed to divert claims from the civil justice system and resolve them faster and more cost-effectively.
- Any ADR demonstration program should be evaluated by the federal government after five years to determine its effectiveness.

<u>Practice Parameters/Guidelines</u>

- Federal support for the evaluation of present and future state demonstration projects to examine the potential for practice parameters/guidelines to improve patient safety and discourage "defensive" medicine.
- The federal government should evaluate the effectiveness of this approach after five years.

<u>Federal Preemption of State Laws</u>

The above uniform standards of federal law should preempt corresponding provisions of state law unless the latter are at least as strict.

<u>Scope of Reform</u>

> The above reforms should apply to any claim arising from health care services offered by health care professionals or institutional providers in any state or territory.

Finally, there has been a great deal of discussion recently that the Administration's health system reform proposal may propose broad implementation of an "enterprise liability" concept which would supplant the traditional individual practitioner liability in all instances where it is practicable. This concept has generally been applied to physicians and hospitals, in which case, liability would be transferred from the individual physician or hospital to the network or health plan.

While the ADA has no formal policy on enterprise liability as such, our initial reaction to such a proposal is that "enterprise liability" would not be feasible for dentistry given the practice modalities of the profession. The majority of dentists are solo/general practitioners who neither practice within a network or under an organized health plan. This type of system would not reduce the risk of individual liability or the need for liability insurance, and it could increase the liability exposure of some by offering additional "deep pockets" to plaintiffs' attorneys. To assure that liability insurance is available and affordable, to guarantee that the public has appropriate access to the courts under a reasonable liability system that is fair and equitable, the Congress should pass real liability reforms similar to those listed above.

The ADA believes that tort reform remains the best means of creating a liability system responsive to the needs of all affected parties and that reforming the system will go a long way to reducing health care costs. We urge that tort reform be implemented as soon as possible and that it not be dependent on the passage of comprehensive health care reform.

Mr. Chairman, we appreciate the opportunity to present our recommendations and look forward to working with you and your staff as the issue of professional liability reform is addressed by Congress.

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MALPRACTICE AND HEALTH CARE REFORM

Malpractice has to be part of health care reform. In a greedy society where we have lawyers who will do anything for a buck, whether ethical or not, we must control the attacks on good descent American physicians. Lawyers have a very poor reputation in America, not because they do such great things for Americans, but because many cannot be trusted. Then they run for Congress and again hurt Americans, innocent children in the womb of mothers, and now forcing homosexuality on moral Americans as a powerful ego trip. It must be noted that lawyers generally have a poor reputation, whether inside Congress or not, and this opinion paper will concentrate on those attorney's who abuse the system of litigation against physicians.

To begin, PRO-PHYSICIAN NETWORK supports physicians who use normal standards of health care to heal patients. We do NOT favor those who abuse standards and deliberately, or irresponsibly harm patients. These few deserve discipline for their poor conduct.

To make this condensed for the record, we want Congress to know what we believe on this issue.

* We believe jury selection should be "peers" and not people who are remotely biased against physicians, or those who are ignorant about the complicated art of healing the human body. Often, a jury has no physicians or medical personnel who understand the medical system, and know the difference between a "bad outcome" and malpractice. Juries should be all physicians. If you can get the same specialty, this would even be better. Let us not pick "lottery" seekers as our juries and see how many millions we can award to an alleged victim.

* We believe a patient who has a claim against a physician should pay out some money up front. Contingency offers those with no case at all, some settlement even outside the court, as a descent physician does not want to tangle his/her life up for two or three years, even when the claims may be false and he/she is innocent. By paying an attorney up front, this will weed out many "lottery" losers who are to cheap to buy a lottery ticket, so they sue a physician. For poor cases, it is like any other civil suit. There are "special interest" groups and lawyers, or the government needs to make legal services like health care and abortion– tax the heck out of everyone and offer this free as a "right" to everyone.

* Because of the abuse by judges and attorneys, many of our excellent OB–GYN physicians have quit doing OB and delivering babies. We are losing very productive physicians and the latest survey of OB–GYN physicians says that 12 percent have quit OB directly because of malpractice abuse.

* We believe the public needs to be educated on the difference between a bad outcome, and malpractice. If a patient is bleeding inside and already dying, and a physician gets involved and tries to save him, but he dies, this is not the physician's fault. The public acts like physician's are God and can fix everything. The fact is, the patient would have died anyway. So why blame the physician. Just so grief can be pad–

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ded with a million dollars? Have we become an irresponsible nation to blame others instead of taking self-responsibility for our lifestyles?

* Forty-three percent of rural Texas physicians reported they limited or eliminated obstetrical and surgical procedures. They are needed, but as long as we blame the doctor for everything that happens, and not the individual, we all lose in Texas and everywhere else this is happening.

* Ninety percent of the cost of immunizations is liability insurance. If these drugs are that dangerous, don't pump them into our children. If they are right to pump into our children, why all the complications and lawsuits?

* In the 70's, 13 U.S. pharmaceutical companies conducted research in fertility and conception. In 1988 there was only one. To mess with the female system, whether infertility to abortion, there are problems.Women are harmed, will always be harmed, and this will create lawsuits. To lie to the public and attest everything is safe, is not fair or right.

* There should be a "pre-trial" with three medical doctors of the same specialty, one the judge picks, one the plaintiff picks, and one the defendant picks, and a decision as to whether there is validity to the suit is done here. If true malpractice is voted from 2 out of three of these physicians, then case goes to trial. If there are probelms, but no malpractice, but disciplinary action or education is warranted so it does not happen again, then the physician is disciplined and put into the National Data Bank with an explanation of the events. If the outcome is bad, and the physician did everything according to proper medical standard, the case ends here. This will save time, money and emotional drainage for innocent physicians.

* There should be fast trials- within 6 months and trial should begin. Several years of waiting and to go through stress knowing you have to go through this and you are innocent- can hurt good physicians. We believe time lengths of 2-4 years is bad because the plantiff gathers every piece of dirt, even if it is not relevant, and maybe only 10 percent pertains to the case, but he/she damages the physician morally and mentally anyway. This is unfair.

* Because of this system, more tests and procedures are done to protect the physicians. They puts a higher cost on health care, and everyone loses.

* Physicians are human. They are never perfect, so they should never be help accountable for perfection. Mistakes are made in every field. Even Congress makes mistakes. Even lawyers. Why must only the physician be held accountable for every little thing done. Can't they be human also?

* Medical malpractice premiums in England are one-ninth of what an American physician pays. As the Honorable Pete Stark travels and searches for the truth of health care, may he also see why they are so low, and make our premiums this low also. Or would he step on fellow colleagues toes who are attorneys and protect their rights over physician's. Now that the President, and Hillary and both attorneys, we'll see what they do in health care reform when attorney's are involved.

*In San Antonio, Texas, medical and non-medical people are joining together in a movement called "San Antonians Against Lawsuit Abuse." Their motto is "Law Suit

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Abuse. We *all* pay. We *all* lose. People are tired of this system and want relief for physicians before we lose good ones, and the system encourages sleek ones to play games with the lawyers.

Abraham Lincoln once said, "Discourage litigation. Persuade your neighbors to compromise whenever you can. Point out to them how the nominal winner if often the real loser in fees, expenses, and waste of time." He was a good Republican with moral belifs to help people– not destroy them.

Malpractice can damage a country, and split it like the abortion issue. They both have one thing in common. They try to destroy good innocent people because of selfish–ness and greed.

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May 8, 1993

Hon. Pete Stark
House of Representatives
239 Cannon House Office Bldg.
Washington, D.C. 20515

RE: Health Care Reform-Medical Malpractice

Dear Pete:

I am dismayed by the May 6, 1993 story in The Recorder to the affect that the Clinton Administration is considering the demand of the American Medical Association (AMA) that non-economic damages in medical malpractice cases be limited to $250,000. A copy of that story is enclosed.

The Legislature and Governor of California caved in to such demands in 1975 and passed what came to be Civil Code Section 3333.2(b), which imposes such a cap in our State. It is unfair special interest legislation that has deprived horribly injured innocent patients of full and fair compensation for harm caused by the negligence of health care providers.

Just one such story will make my point. A man in his fifties had cancer of one kidney and was operated on at the Long Beach Memorial Hospital. The doctors removed the wrong kidney and he was left with no kidneys. His life expectancy was reduced by 13 years and the jury awarded him full and fair non-economic damages of well over $1,000,000. But, because of Section 3333.2(b) the trial judge was required to reduce the award to $250,000.

This innocent patient was forced against his will to subsidize lower medical malpractice insurance premiums for the highest paid profession on average in California. (As of last year, according to the AMA, the average annual income of its members was over $190,000).

The incidence of medical malpractice in the U.S. is no small matter. According to Ralph Nader there are at least 80,000 deaths per year in the U.S. caused by medical malpractice in hospitals. Enclosed please find copies of two stories written by him. His projections were based on research by the Harvard Medical School, which I am sure was conservative in determining its numbers. Hence, the true figure is probably more than 80,000. Also, those numbers do not include medical malpractice deaths outside of hospitals.

Doctors cause 1.4 times more deaths of Americans in one year than did the Viet Cong in 13 years of war in Southeast Asia. In the last 13 years doctors have killed more Americans than all those who lost their lives in all of the wars involving Americans since 1775. (According to THE WORLD ALMANAC AND BOOK OF FACTS-1993, page 698, the total lives lost in those wars was 1,044,155).

How many injuries other than deaths are caused by medical malpractice each year in the U.S.?

Since I am not a medical malpractice specialist I do not have much information about that question. But, recently the U.S. Centers for Disease Control released a report on births by Caesarean section. The story in the New York Times of April 23, 1993 is enclosed. The Centers have found that each year doctors perform 349,000 unnecessary births by Caeserean section out of a total of 966,000 Caeserean section births. Hence, 36.13% were not necessary. I heard on KCBS this morning that it cost on average about $3,000 more to do such a procedure as compared to a normal birth. Hence, the public pays no less than $1,047,000,000 in unnecessary medical expenses. I am sure that the Centers were very conservative in making the calculation of 349,000, knowing there work would be challenged by the medical establishment.

How many other unnecessary operations are performed each year in the U.S.?

The purpose of this letter is to request that before any health care reform is debated on the floor of the House, that there be public hearings on and facts gathered as to the following issues:

1. How many deaths in the U.S. each year are caused by medical malpractice?

2. How many injuries in the U.S. each year are caused by medical malpractice?

3. What is the increase in the cost of medical care caused by medical malpractice?

4. What are the economics of the medical malpractice insurance industry?

5. What can and should be done to reduce the occurrence of medical malpractice in the U.S.?

6. How much money was contributed by the health care establishment to members of Congress and to the Clinton campaign?

I believe that the American people have a right to know the truth about these questions as a part of the process of creating a well thought out health care reform plan.

If the Congress and the Administration are going to give such unfair financial benefits to the medical establishment in exchange for support on health care reform, then I believe that they have a moral duty to know the harmful consequences of any such deal on innocent victims of medical malpractice.

In my judgment it is outrageous to give the wealthiest profession in the U.S. financial benefits paid for by the innocent victims of medical malpractice.

My intention is to seek from professional friends, who are medical malpractice specialists, more factual information about these issues and pass it on to you.

Very truly yours,

Lee

A. LEE SANDERS

ALS/dm

P.S. When Section 3333.2 was passed in 1975 the California Medical Association was one of the largest, if not the largest, maker of campaign contributions to members of the Legislature. There political money paid off and innocent victims of medical malpractice paid the real price.

LIBERAL OPINION March 29, 1993 Page 8

Ralph Nader

Special Interests Shaping Health Care Reform

Watch out folks, the strategy of the Clinton task force on health care reform is becoming all too clear.

Racing to meet a self-imposed May 1, 1993 deadline for the White House's proposal to Congress, dozens of White House staff, directed by Hillary Clinton, and hundreds of consultants are weaving a restruc-

In The Public Interest

turing of one-seventh of our national economy. That is $925 billion in health care bills in 1993 alone.

The White House is proceeding on two tracks here. One track ostentatiously declares that the task force will not meet with special interest groups. Hillary and the cameras go out around the country to meet the people and hear their complaints and desire for universal health care coverage. Back at the White House, academics from universities and think tanks go to and fro consulting. Look Ma, no lobbyists invited.

Clinton's track two is far less flamboyant and media-drenched. The name, shape and nourishment of Clinton's emerging plan comes from Jackson Hole, Wyoming Group. There for many months members of the upper crust have been privately meeting, deciding, then fanning out and spreading their proposal called "managed competition" to the business, academic, political and media worlds.

They virtually own the New York Times editorial position through a staff writer who was a protege of one of the Jackson Hole crowd.

Let the president of Consumers Union, Rhoda H Karpatkin, describe what the Times called "Hillary Clinton's Potent Brain Trust:" "The list of 35 key participants reads like a "Who's Who" of health special interests: top executives of six insurance companies, three pharmaceutical companies, two hospitals, three H.M.O.'s, physician groups, four business groups, a data processing giant and a pacemaker manufacturer. In addition, there are five academics — three with medical degrees — and five political leaders. Prominent are the heads of the American Medical Association and the Pharmaceutical Manufacturers Association."

"Whatever differences may exist among its members," Ms. Karpatkin says, "the Jackson Hole Group has a powerful, shared interest in preserving as much as it can from the existing, discredited system."

"Managed competition" envisions the formation of giant health insurance purchasing cooperatives, composed of businesses and individuals, which would connect with a giant health care provider (like HMOs) to provide a minimum health care packages. If you want more, you pay more. Everybody by the end of the decade would be covered and billions of dollars to cover the poor will come from taxes, such as sin taxes (tobacco, alcohol, etc.).

The Jackson Hole group believes that these big buyer-big seller negotiations will incite market competition and greater efficiencies.

Without going into the ailments of this plan (a later column will do that), it is interesting to observe how the major corporate and professional players are falling in line. Among others, the American Medial Association, the Pharmaceutical Manufacturers Association and most recently, a group of employers calling themselves HEAL, are openly signing on to "managed competition."

These vested interests want to preserve the essence of the status quo and, in turn, Clinton wants all these players on board behind his May 1st plan. That would make passage of the plan through Congress quicker and Clinton can say he kept his campaign promise. But at what price to consumers?

Already Clinton is offering the supportive vested interests sweeteners. In an obvious leak to the New York Times earlier this month, the White House let it be known that in return for limits on doctors' fees (a *sine quo non* anyway for any kind of reform to contain costs), the Clinton Administration would propose restrictions on medical malpractice lawsuits.

Nothing in the leaker documents to the Times recognized the need to do something about *preventing* medical malpractice which takes over 80,000 lives a year just in hospitals (extrapolation from a recent landmark Harvard study of New York hospitals).

The focus instead was on making it harder for the most seriously harmed patients to secure adequate compensation for their pain, suffering and long term expenses by capping arbitrarily from Washington what damages state juries and judges can award.

Nothing was said in these documents about limiting the almost embarrassing profits of the medical malpractice insurance companies who are gouging physicians with high premiums and paying out proportionately less and less to victims.

Get ready for a disappointment on May 1st or get ready for a grass roots reaction by people everywhere that spells the following message to the Clintons — "no more con jobs in the name of reform."

LIBERAL OPINION April 5, 1993 Page 1

Medical Lobby Bungles Malpractice Epidemic

The American Medical Association (AMA) came to Washington, D.C. the other day with 1000 physicians to lobby the Clintons and the Congress on health care policy. They gathered in the Mayflower Hotel on Connecticut Avenue and then fanned out to Capitol Hill to see what response they would receive from all those politicians greased by millions of dollars of campaign contributions from AMA Political Action Committee and affiliates.

The medical lobby, led by the AMA, blocked President Harry Truman in the early Fifties from enacting national health insurance. That was a devastating blow to millions of Americans in subsequent years who could not afford health care and had no one to help them counter the powerful AMA.

In the mid-Sixties, the AMA only relented after they got the kinds of changes made in the medicare law that assured payment of doctors' bills. For years there was no organized force against the AMA, except the part-time efforts of some labor unions pressing for universal coverage.

Now the AMA finds its membership slipping as a percentage of practicing physicians. Other physician associations such as the American College of Physicians are rising in influence and are more progressive. But the AMA has not changed its colors.

It is still opposing genuine restraint on physician fees and prices. It is fighting Congressional and state efforts to end self-referrals to laboratories and other physician owned centers whose conflict of interests increase the number and costs of procedures. And it wants to make victims of serious doctor malpractice have an even harder time obtaining compensation for often horrible injuries.

What is so notable about the AMA is its absence of any compassion for the hundreds of thousands of Americans yearly who are killed, injured or rendered sick by bad doctors and bad hospitals. The word "malpractice" does not convey the agony of the kind of negligence or worse that one California physician once called "mind-boggling".

The most careful study of medical malpractice was published in 1990 by the Harvard School of Public Health for the NY Department of Public Health on rural, suburban and urban hospitals in New York state. Their very conservative estimate of the number of people in the Empire state who died in hospitals due to malpractice, projected nationwide to 80,000 Americans a year, illustrates some of the scope of this institutional violence. Add to that casualty toll the number of injuries and illnesses and one can sense its seriousness. By comparison, about 40,000 people will die on the highways this year.

So instead of the AMA launching a major drive to toughen the peer review system, to strengthen the medical licensing review boards in the fifty states and to focus on prevention of this toll of trauma and infection, this stubborn guild spends its muscle on legislatures to weaken rights of victims to obtain justice, to have their day in court, if necessary.

So wagon-circling is the AMA that when they refer to the malpractice crisis, they mean the litigation, not the malpractice epidemic of death and injury itself.

Actually, the volume of payouts for verdicts and settlements for malpracticed patients has been falling in the past five years relative to the overall amount spent on health care. In 1991, the latest available figures, the total was under $3 billion or what this country spends on dog food. As for the premiums collected by the very profitable malpractice insurance companies, the doctors and hospitals paid nearly $4.9 billion or only six-tenths of one percent of what was spent on health care that year.

Last week, the AMA office in Chicago was asked whether the Association had information on how many deaths and injuries were attributed to malpractice? No information said the spokesperson. Well, then, how many malpractice suits against doctors were there? No information, said the spokesperson. The AMA knows the best estimates, but doesn't want the public to know.

Confronted by these deflating figures, the AMA cries out, "but there are the costs of defensive medicine." Where is the hard data to show that all such procedures and operations are due to fear of malpractice claims and not simply fee generating business or just careful medical practice?

The Congressional Office of Technology Assessment is in the middle of a two year study of so-called "defensive medicine." The researchers have found no "good data" on "defensive medicine." What they are finding, observers suspect, is that more than a little "defensive medicine" is itself a form of medical malpractice.

NEW YORK TIMES Friday, April 23, 1993 Page A16

349,000 Caesareans in '91 Called Unnecessary

ATLANTA, April 22 (AP) — Doctors performed 349,000 unnecessary Caesareans in this country in 1991 at a cost to the nation of more than $1 billion, the Centers for Disease Control and Prevention said today.

But the number of mothers who delivered vaginally after a previous Caesarean is rising to 108,000 in 1991 — or 24.2 births per 100 deliveries, up from 20.4 in 1990, according to the latest figures from the agency.

"That's the good news," said Dr. Sidney Wolfe of the consumer group Public Citizen in Washington. "Women need to know that the fact they had a C-section once does not mean they have to have C-sections from then on."

Among the 966,000 Caesarean deliveries in 1991, about 35 percent were repeats. The overall Caesarean rate was 23.5 per 100 births, unchanged from 1990. Only Brazil and Puerto Rico reported higher rates.

Federal health officials hope to lower the rate in the United States to 15 Caesareans per 100 births by the turn of the century, a rate the Centers for Disease Control deems medically appropriate. But the goal will probably not be met, said Selma Taffel, a statistician at the agency.

"It's going to be extremely difficult," Ms. Taffel said. "We would have to have a rather large reduction in the primary Caesarean rate, and the primary rate has not changed substantially since 1986."

The American College of Obstetricians and Gynecologists has also said that the Caesarean rate was too high but has opposed setting a national target rate.

Rare at one time, Caesarean sections, the surgery in which an obstetrician cuts open the uterus to deliver the baby, can cause infection and longer hospital stays. But the rate soared, from 10.4 births per 100 in 1975 to 24.7 births for every 100 in 1988.

THE RECORDER Wednesday, May 5, 1993 Page 9

Giving and Taking Away

MICRA recovery caps have sought to restrain malpractice premiums at the price of inadequately compensating the injured

By LINDA M. BALDWIN,
JAY LEE,
TANYA NERO
and QUANG NGUYEN

In 1975, the California Legislature enacted the Medical Injury Compensation Reform Act to avert a crisis in suit-related health care costs. The statute allows for a $250,000 noneconomic damages cap and the dispersion of payments when recovery is equal to or over $50,000. These provisions have caused a great deal of controversy.

Those who support the cap believe it is an effective way to lower insurance premiums because it eliminates huge noneconomic damage awards. Further, the dispersion of payments can mitigate the burden that a lump-sum payment may place on insurance companies. However, because victims often accrue huge medical bills, they need immediate and full compensation. Moreover, critics argue that the cap discriminates and imposes an undue burden on those most severely injured, especially young children.

Although MICRA may have been enacted with good intentions, it is fraught with problems. It is imperative that the Legislature take measures that will lower malpractice insurance premiums while ensuring adequate compensation. Proposals that merit serious consideration from the Legislature include eliminating the recovery cap, restructuring the Board of Medical Quality Assurance, and initiating a lump-sum payment option that is supported by the MICRA Compensation Fund.

Under current law, an injured plaintiff is limited to $250,000 for the remainder of her or his life. MICRA does not take into account age, life expectancy, overwhelming medical expenses and heightened cost of living. Critics argue that exorbitant noneconomic damage awards are bankrupting insurance companies. However, large damage awards are rarely given. *Fein v. Permanente* stated that in the years prior to the enactment of MICRA "a maximum of 14 victims received compensation over $250,000 with both noneconomic and economic damages combined." Insurance companies' efforts to reduce and control the rising costs of medical malpractice insurance premiums should not dictate how we compensate injured victims.

Next, the Board of Medical Quality Assurance needs revamping. A 1989 study by the Center of Public Interest Law revealed that of 6,000 malpractice complaints heard by the board in 1987 only 42 resulted in suspension or revocation of licenses. Currently, the majority of the board is comprised of physicians who neither have the time nor objectivity to effectively review their colleagues. The board should also include arbitrators and consumer advocates. The changed makeup of this panel would facilitate impartial decisions and encourage greater disciplinary action.

Finally, a lump-sum payment option should be considered. This payment system would replace the current periodic payment scheme by allowing the plaintiff to choose the payment plan that will best accommodate the circumstances. While insurance companies criticize this plan because it allegedly places heavy strains on the system, this payment scheme is feasible if implemented in conjunction with the MICRA Compensation Fund.

The MICRA Compensation Fund would ensure timely payments and reduce the total amount expended by insurance companies for medical malpractice damages. All insurance companies would have to make a mandatory contribution to establish the fund. Pooling all of the assets would allow the fund to diversify the risk through a variety of investment vehicles such as certificates of deposit, mutual funds and bonds. Over a three- to five-year period, the investment income generated from the fund would offset the amount of lump-sum payments the insurance companies would have to contribute. Since most insurance companies provide both institutional and private investment options and manage them effectively, their industry expertise would be beneficial.

MICRA needs modification. The state's interest in lowering malpractice premiums has overshadowed the responsibility to adequately compensate the injured. These proposed modifications will allow these two important interests to coexist. ■

THE RECORDER Thursday, May 6, 1993 Page 6

Clinton Team Eyes Ban of Malpractice Suits

ASSOCIATED PRESS

WASHINGTON — President Clinton's health care advisers are considering a proposal to bar patients from suing their doctors for malpractice, though they could sue their health plans instead.

Clinton's team has discussed the idea, called "enterprise liability," with doctors' and hospital groups as well as consumer organizations.

Kirk B. Johnson, the American Medical Association's general counsel, said some White House advisers "have made at least a preliminary decision that [enterprise liability] ought to be the centerpiece of liability reform."

The White House task force is eyeing other possible changes in malpractice law, including caps on damages for pain and suffering and encouraging patients and providers to resolve disputes without going to court.

Consumer groups and organized medicine alike have misgivings about the possible changes, still being debated within the White House.

Enterprise liability has been championed by two academics, Paul C. Weiler of Harvard Law School and Kenneth S. Abraham of the University of Virginia School of Law, who argue that malpractice suits should be aimed at organizations, not individuals.

Institutions already bear the malpractice liability in most other fields, said Weiler. "If an airplane crashes due to a mistake made by a mechanic, it's the airline company that's the target of liability."

"Our proposal is to shift the focus of liability from the individual doctor to the hospital or HMO or other enterprise under whose auspices the patient's care has been delivered," he said.

Doctors have long clamored for relief from malpractice suits. They spend $5.6 billion a year on malpractice premiums.

The administration, for its part, wants to get doctors to stop ordering costly tests and procedures simply to protect themselves from being sued.

A recent study by the consulting firm of Lewin-VHI Inc. estimated Americans could save $36 billion over five years by curbing so-called defensive medicine.

"Enterprise liability is sort of a black hole," said Gene Kimmelman, legislative director for the Consumer Federation of America, who said it was unclear whether injured patients would get more redress or less under such a system.

Malpractice revision has been a staple of Republican proposals to rein in health costs. It could help Clinton sell his package to the GOP minority in Congress and to doctors at large.

But Clinton runs the risk of alienating consumer and labor groups if he tries to impose "Draconian limits on what people can recover," said Kimmelman.

Johnson said the AMA was more interested in getting malpractice reforms like those in California, which limits pain and suffering damages to $250,000, allows periodic rather than lump sum payments of big awards, and encourages juries to deduct what a patient gets from health insurance and workers' compensation.

ISSUES RELATING TO ADMINISTRATIVE SIMPLIFICATION

TUESDAY, MAY 25, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to call, at 10 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
TUESDAY, MAY 18, 1993

PRESS RELEASE #12
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING
ON
HEALTH CARE REFORM:
ISSUES RELATING TO ADMINISTRATIVE SIMPLIFICATION

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on issues relating to administrative simplification on Tuesday, May 25, 1993, beginning at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.

In announcing the hearing, Chairman Stark said: "The current system of processing claims costs too much and imposes unnecessary paperwork burdens on hospitals, physicians, and patients. This crazy-quilt of regulations and requirements wastes money that could be better spent providing access to insurance for the uninsured."

Oral testimony will be heard from **invited witnesses only**. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND:

National health expenditures in the United States have escalated to more than $900 billion this year.

According to the Congressional Budget Office, approximately 10 percent of national health expenditures are spent on administrative overhead of both providers and insurers. Depending on the type of health care reform adopted, as much as $50 billion could be saved by simplifying the administrative burden on insurers and providers.

A variety of proposals have been suggested to reduce administrative costs. Many of these would be consistent with any type of overall health care reform strategy. Among the administrative reforms that have been suggested are:

1. Use of standardized, electronic health insurance cards, with appropriate confidentiality and privacy protections;

2. Requiring the use of uniform claim forms and coding systems that would be accepted by all insurers and public payers for electronic billing;

3. On-line verification of eligibility and benefits through direct access to payer computer systems;

4. Processing of all claims through regional consortia;

5. Use of electronic medical records for both medical and administrative support which, subject to appropriate privacy protections, could be used in extracting data for responding to requests from utilization review entities;

(MORE)

6. Electronic transfer of funds between payers and providers; and

7. Development of standardized audits and screens to be applied to bills by all insurers and public payers.

In general, the methods and the technology for simplifying the administration of health insurance exist and have been tested.

For example, a uniform bill for hospital services, the "UB-82," has been in use for a decade, but is not used in a uniform way due to the variety of additional requirements imposed by insurers. Bills are already submitted electronically to many payers, including Medicare. Currently, Medicare processes 77 percent of hospital claims and 44 percent of physician claims electronically.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Tuesday, June 1, 1993, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

* * * * *

Chairman STARK. Good morning.

Today the subcommittee will continue its series of hearings on health care reform with a discussion of administrative simplification which we hope can save billions of dollars each year on excessive paperwork. These costs, of course, don't contribute at all to improving our health care system, and, hopefully, we can eliminate them.

Simplification is an important part of the reform package, and reducing the administrative costs and the burdens of the health insurance system is one area where broad consensus exists.

Reducing the administrative costs in health care through the use of electronic billing, smart cards and other measures is something which we agree we must explore. Whether we support a Canadian-style system, Medicare-for-all, managed competition or any other plan, we need to move aggressively to put these cost-saving measures in place.

There is wide agreement on what could be done to reduce the administrative expenses of the health care system. Much of what needs to be done is based on existing information-processing technology. This is not an area in which we need to invent a new set of policies or processes in order to achieve our goals.

The issues we need to explore in order to simplify the system include:

The use of a standard health insurance card format by all insurers and payers; a universal and unique numbering system for identification of both providers and beneficiaries; creation of electronic billing systems based on standard formats and standard coding, both of diagnoses and procedures; and a method of verification electronically of eligibility and benefits; the use of clearinghouses; payments using electronic transfer of funds; development of standards for audits and screens applied to bills by all insurers; and standardization of the data required to support utilization reviews and analysis.

I think it goes without saying that the issue of privacy is one that will be kept paramount in our minds, and, as we look at privacy, I think one has to look at privacy in the context of the 21st century. It is not the same privacy standards that applied in medieval England when privacy was the curtilage or boundary of your farmyard and could not be crossed.

We must understand that some sharing of data protected for individual identification will be useful to all of us, and I hope that as we look at the privacy issue we can look at it in terms of modern convenience. We need to address these issues and achieve a high degree of automation.

Where consensus breaks down is how far we should go in developing uniform approaches, and what should be the role of government in assuring the approaches are, in fact, used by all payers and providers.

Many providers are already beginning to change their ways of filing claims and keeping records, but our experience to date suggests that voluntary efforts will not be very successful. If there are several kinds of voluntary programs, these programs will have cheerleaders who don't want to cooperate with other voluntary programs

and then we are back in the same soup that we are trying to get out of.

Private sector providers and insurers tend to develop specialized billing systems that prevent these electronic systems from achieving their own potential. As an example, consider the history of UB–82, the uniform bill for hospitals. Since this form was developed in 1982, insurers imposed differing requirements for payment and utilization review. As a result, the providers were not able to streamline their information systems to take advantage of the simplification that would have resulted from this uniform claim.

Clearly, the Federal Government can assist these ongoing efforts by establishing appropriate standards. It very well may be that we cannot achieve the administrative simplification that we seek unless all claims for payment are handled by a single clearinghouse system that would enforce standardization of claims and data.

The bottom line is that the costs of health care continue to rise at unconscionable rates. Whether we favor broad change or something less sweeping, we all share the goal of reducing overhead costs and hassle.

Simplification demands our attention now, and I know our witnesses today are prepared to offer suggestions to the subcommittee on reducing administrative costs and burdens so that we can move quickly.

Earlier this year, I introduced a bill, H.R. 200, that included a proposal regarding administrative simplification. I hope this hearing will provide an opportunity to discuss the issues covered in that bill and to consider how these proposals could be perfected.

I look forward to our witnesses' recommendations.

[Chairman Stark's opening statement follows:]

OPENING STATEMENT

THE HONORABLE PETE STARK

HEARING ON
ADMINISTRATIVE SIMPLIFICATION IN HEALTH CARE

May 25, 1993

Today the Subcommittee continues its series of hearings on health care reform with a discussion of administrative simplification. We will be discussing how we can save tens of billions of dollars a year which currently are spent on excessive paperwork. These costs don't contribute to improving our health care system, and should be eliminated.

Administrative simplification is an important part of health care reform. Reducing the administrative costs and the burdens of the health insurance system is one area where a broad, bi-partisan consensus exists.

Reducing administrative costs in health care through the use of electronic billing, uniform bills, "smart cards" and other similar measures is something on which we can all agree. Whether we support a Canadian-style system, Medicare-for-all, a system based on employer mandates, or some other plan, we need to move aggressively to put these cost-saving measures in place.

There is wide agreement on what could be done to reduce the administrative expenses of the health care system. Much of what needs to be done is based on existing information processing technology. This is not an area in which we need to invent a new set of policies or processes in order to achieve our goals.

The issues which we need to explore in order to simplify the administration of the health care financing system include:

1. The use of a standard health insurance card format by all insurers and payers, which could be read electronically

2. A universal and unique numbering system for identification of both providers and beneficiaries;

3. Creation of electronic billing systems based on standard bill formats and standard coding of diagnoses and procedures;

4. Electronic verification of eligibility and benefits;

4. Use of regional claims clearinghouses;

5. Payments using electronic transfer of funds;

6. Development of standards for audits and screens applied to bills by all insurers and public payers; and

7. Standardization of the data required to support utilization reviews and analysis.

Consensus exists on the need to address most of these issues; moreover, the information processing technology exists to achieve a high degree of automation in each of these areas.

Where consensus breaks down is on how far we should go in developing uniform approaches in each of these areas, and what should be the role of government in assuring that uniform approaches are in fact used by all payers and providers.

While many providers are already beginning to change their way of filing claims and keeping records, our experience to date suggests that voluntary efforts will not be totally successful.

Left on their own, private-sector providers and insurers tend to develop idiosyncratic billing and payment systems that prevent these electronic systems from achieving their potential. As an example, consider the history of the UB-82, the uniform bill for hospitals. Since this form was developed in 1982, insurers imposed differing requirements for payment and utilization review. As a result, providers were not able to streamline their information systems to take advantage of the simplification that would result from use of a uniform claim.

Clearly, the Federal government can assist these ongoing efforts by establishing appropriate standards for these systems.

It very well may be that we cannot achieve the administrative simplification which we seek unless all claims for payment are handled by a single clearinghouse system that would enforce standardization of claims and data.

The bottom line is that the costs of health care continue to rise at unconscionable rates. Whether we favor broad change or something less sweeping, we all share the goal of reducing overhead costs and hassles.

Administrative simplification demands our attention now. I know our witnesses today are prepared to offer good suggestions to the Subcommittee on reducing administrative costs and burdens on which we can move quickly.

Earlier this year, I introduced a bill, HR 200, that included a proposal regarding administrative simplification. I hope that this hearing will provide an opportunity to discuss these issues, and to consider how these proposals could be perfected.

I look forward to hearing our witnesses' recommendations.

Chairman STARK. I would like to recognize the distinguished ranking member, Bill Thomas, for an opening statement.

Mr. THOMAS. Thank you, Mr. Chairman.

It seems to me of all the hearings that we have held and are going to hold this is the one that offers the most promise in terms of coming to a mutually agreed upon resolution and moving forward. Whether or not we move to a broad, comprehensive restructuring, obviously, in administrative simplification, it would be easier done if we made some fundamental restructuring which provided a less complicated system in which to unify. Nevertheless, I think we need to move forward, and this is one of the areas.

Mr. Chairman, you indicated that you had introduced a bill earlier this year. Republicans in the 102d Congress had a provision in their Action Now Health Care Reform bill dealing with administrative simplification which, if we compare, might determine where we have broad areas of agreement and, in particular, areas of disagreement.

The members of this subcommittee have unanimously endorsed introducing a bill which contains a number of provisions, many of them similar to the one that you just outlined as a kind of an ideal model, especially in terms of structuring an administrative simplification form that would have the Health and Human Services Secretary reach out to all of the task forces, the private sector, the National Association of Insurance Commissioners and so on to make sure that the net is cast as broadly as possible to come up with a plan that everyone is in support of. And we firmly believe that all hospitals, physicians, insurance carriers should be required to conform to a uniform standard. There should be universality involved.

It seems to us Social Security numbers are the easiest structure to use, and, as you indicated, the protection of privacy is critical. There are ways in which we can put a number of screening devices to guarantee a degree of privacy, but I also believe the public's right to know has to be balanced against the privacy, and, to a certain extent, we believe electronically we can structure arrangements which would guarantee that.

We also need to be sensitive to States' concerns in this area, but our bill contains a provision which will prevent States from arguing that you can only send information or claims electronically. We think that is an appropriate 21st century structure.

In addition to that, Mr. Chairman, our bill will involve a clearinghouse by HHS in terms of information on primary and secondary payers for Medicare recipients, and we would move to a magnetized Medicare card issued by the Secretary.

In addition to that, we believe by January 1, 1996, in the bill that all hospitals would be required to put in place electronic patient care information, meeting the standards established by the Secretary.

And then, finally, one of the keys to any system is consumer information, and we think that on the comparative value, information, decisionmaking structure that States should be required to make available to consumers information on the comparative value of medical services.

So I believe, Mr. Chairman, we have a number of areas in which we have agreement not just with policymakers but bureaucrats and the private sector as well. It seems to me that if we can move forward on broad agreement, establish that communication net and move forward in this area, regardless of what occurs in other areas if we can put this in place even with the current system, it would be a tremendous step forward, and I look forward to the testimony not only of our colleagues but of others.

Thank you, Mr. Chairman.

Chairman STARK. Thank you.

Are there other members who have statements?

If not, I would like to welcome our first witness, the gentleman from Missouri, Senator Bond.

Senator, welcome to the committee. We appreciate your concern and your support for simplification in this system. Your presence here speaks to the fact that this is an issue that has strong bipartisan support. I know the distinguished gentleman has some understanding of the problems of privacy and electronic data and other areas of which we all are concerned for not only ourselves but for our constituents, and we look forward to your advising us of your viewpoint on this situation.

Your complete statement will appear in the record as part of today's hearing, and we welcome you to expand on it or enlighten us in any manner you feel comfortable. Please proceed.

STATEMENT OF HON. CHRISTOPHER S. BOND, A U.S. SENATOR FROM THE STATE OF MISSOURI

Senator BOND. Thank you very much, Mr. Chairman, Mr. Thomas, members of the committee.

I have received records, statements for the record before, and I will count on somebody appropriately reading this material as and when they feel it is incumbent upon them, but I would like briefly to summarize what we are attempting to achieve in a measure introduced last year and will be introducing very shortly this year.

The first impression that the average consumer has—and that is you and me, our families—of the administrative system of health care is when they are required to fill out a very complex form that at least in my family we always get it wrong the first time around. I understand that this costs the health care system anywhere from—the New England Journal of Medicine says $50 to $80 billion. The Congressional Budget Office says $126 billion.

On the other hand, when we go to a bank ATM we slip in a little card like this and it knows to pay us money. I think with a dumb card like this, if we establish the appropriate standards and protections of confidentiality and security, that we will see a revolutionary change in the administration. What is the savings? Nobody can say for sure, but I think tens of billions of dollars is a likely figure.

Secondly, I think for the consumer to know that if he or she is away from the normal health care provider and gets sick to have a dumb card like this which could permit an emergency room health care giver to get information on that patient's well-being or conditions would be a great step in the right direction.

Beyond that, we know that there are instances of fraud and abuse, and there have been some eye-popping figures of the dollars

of fraud that occur in the Medicare program alone, for example. Certainly an electronic information system would give us better tools. Health care seems to be the only major industry we have today that doesn't use 20th century techniques.

Beyond the fraud, just appropriate practices, unnecessary practices with an effective information system we will begin to identify what works and what doesn't work.

Is there excessive utilization? These questions can best be dealt with if we had an adequate, up-to-date, modern information system. Long-term outcomes research and many other factors will depend upon an effective information system. And I would say, with respect to the various competing health care reforms that will be considered in this body and the other body and the White House, whatever way you go in health care reform, you have got to have information, you have got to know where you are and where you are going.

Now, the three major things that are problems today with going to a system like this is establishing a standard format. We all know from UB–82 and now 92, we tried to prescribe a single form, and everybody adds on to it, and they don't look anything alike. Our bill will set up a governmental standards board in consultation with the effective disciplines and the industries to establish what the standards of information would be.

Beyond that, we must have some protection for the confidentiality, the privacy rights, and the third, obviously, security for the system. This would build in confidentiality provisions. A lot of people would be very concerned if they knew today the extent of the health care information now available about them. It is not a question of does somebody have information on your innermost ailments and your most private concerns. It is a question of are those bits of data available.

We want to establish tough standards to make sure that they are available only to you and authorized persons. That is what we proposed last year.

We have had continuing discussions and input. Everybody has found a concern or a question about the numerous drafts we have gone through. We are continuing to go through drafts. I believe that we have dealt with many of the concerns, but we will be introducing a bill, and we would look forward to working with you, the members of this committee, to see if we can't iron out a reasonably good version that could pass to establish the framework for genuine health care reform.

Chairman STARK. Thank you very much, Senator.

[The prepared statement follows:]

Health Information Reform

Testimony by Senator Christopher S. Bond

House Ways and Means Committee
Subcommittee on Health

As in many things, in health care having the right information at the right time is the key to success. Without the right information at the right time quality of care suffers. That information might be about the patient's prescription drug therapy, previous complaints, or the results of a lab test. That information also might be a study of the latest proven therapy or practice guidelines that recommend a course of therapy for a particular diagnosis.

No one knows for sure how much we spend solely on administration. The estimates range up to a $126 billion estimate by the Congressional Budget Office. Likewise no one knows how much we waste on unnecessary or questionable procedures. Researchers at the Rand Corporation in a well known study found that as much as one-third of medical procedures are "less than appropriate," and that 15 to 30 percent of hospital use was unnecessary.

Health care professionals are not to blame. When one stops to consider the importance of information to quality clinical decision making in an increasingly complex health care system and the depth of medical knowledge today's health care professional must have at hand, it is perhaps a miracle that the health care system works as well as it does.

Today's health care system is still largely in the information dark ages where health care professionals are reduced to information hunter-gatherers. Developing a viable health care information system is necessary if we hope to bring down the

costs of administration and learn where we are wasting dollars on tests and procedures where there is little or no benefit.

In addition to the benefits to quality of care that would result with an effective health care information system, such a system would alleviate a curse that vexes doctors and patients alike: mounds of paperwork. Everyone in this room has probably faced the pile of health forms at one time in their lives and understands that this is one problem where no one is fighting for the status quo. It probably comes as no surprise, but Medicare and Medicaid are some of the worst when it comes to aggravating and confusing paperwork.

When the subject of reforming our health care system comes up, there is no issue that I can think of that receives broader support than reducing administrative costs. Yet the issue is as complex as any other in health care. With this issue, like many others, some assume there is a simple one-page solution. There isn't.

I have been working with experts in this area for over a year to develop a legislative proposal to forge a solution to the problems that have prevented such an information system from being developed. That bill, the Health Information Reform Act will be introduced shortly.

My goal has been to develop an appropriate public/private partnership with the least intrusive role for the federal government. The high-tech companies that will make this system work don't need the federal government to tell them how to do it, they need government to facilitate the process, not be part of the problem and then get out of the way.

The most important task for the federal government is to secure the privacy and confidentiality of a patient's medical data. Some have voiced their reservations about having their

medical information in a computer where someone might get to it. But don't be fooled, there is a tremendous amount of medical information that is already stored and transmitted by computer even as we sit here today. Current federal privacy laws for medical information are inadequate and this alone demands that we enact legislation expeditiously to ensure that the guarantee for patient privacy and confidentiality is ironclad.

We should not hold up these changes while the nation debates comprehensive reform of the health care system. The information system is a fundamental infrastructure that should be put in place before the enactment of health care reform. Just as this information system will simplify and reduce the costs of administration, so too would it simplify the difficult transition period that lies ahead as we re-tool the financing structure of health care and bring access to health care to those who do not have access today.

The bottom line is that Congress should act without delay to improve the health information system and to secure patient privacy and confidentiality. I would be pleased to work with this Subcommittee to facilitate this process and I hope that we can do so.

Chairman STARK. I just have a couple of questions.

I concur with the points that we have before us. You mention that there has to be government standards, either a government board or some kind of a quasi-government board. Would you be comfortable with the amount of Federal involvement, that the Federal Reserve now has in the transfer of bank funds and of processing of checks? I am just trying to get a sense of your comfort level with how much Federal involvement and how the Federal-private partnership would work.

As an ex-banker, I keep looking at that and that has never really caused much problem. The banks run it. It has a Federal control. And it has served that industry very well for a number of years. Would that mix of private-public control and involvement satisfy your comfort level?

Senator BOND. See, in some ways the Federal Reserve has a great deal of control over the monetary supply. They are actively participating in the banking system. They have many responsibilities that go far beyond what I would envision for this board.

Chairman STARK. I am just talking about check clearing which is really a separate division of the Fed and has nothing to do with their open market operation. They just operate, basically, a paper-shuffling operation which has become more electronic at the convenience of the bankers.

Senator BOND. Well, I think to the extent that there are—there are various entities that could do this beyond one single entity I would not envision the Federal Government having any implementing role in it.

To the extent that the Federal Reserve is involved in the day-to-day operations, I think that this board could establish the standards. And there would be, I would imagine, a number of different organizations offering their services to provide information and to handle claims under the system, and I would prefer to see a number of different ones trying it all under the same standards format and see who does it best and devil take the hindmost.

Chairman STARK. That is what happens in the banking industry today. Let me just explore that a little further because I am not sure we are that far apart.

In days gone by, the banks that the Fed operated around the country actually operated much more like banks. You deposited checks. They were paid there. But many banks in small towns, State banks, didn't go through that. They just exchanged checks in town. And, as it is now with Visa or MasterCard, they may very well exchange credits within the credit card system, but they still use the protocols established a long time ago by the Federal Reserve. And I would submit that the Government pays about a third of the bills that are submitted in the country and probably could continue to do that and thereby set the standard.

If other people wanted to follow that—because we have a voluntary problem here. I am not sure we can force everybody into it. We might set the lead and still leave plenty of room for private entrepreneurs to participate in the system, but somehow we have got to get that Federal part established.

And I would just, before my time expires, take the second step here. I have always felt—and, again, this goes back to my banking

days—that the simplest, number that we could use would be the Social Security number. Arguably, for people who don't have one for one reason or another we would have to find another unique number, but I have always been troubled with the idea that we have to invent a new number, and I have trouble remembering my first number as it is now, much less 7- or 10-digit phone numbers. Would using either the taxpayers' identification number or Social Security number, as the case may be, create any problem for you?

Senator BOND. I think that you are going to have to have security over the numbers. There have been stories in the press recently about sophisticated credit card scams where people are looking over the shoulders to copy down the Social Security numbers. That is going to happen with any kind of number.

My State of Missouri used to have an automobile license number that was somewhere between 35 and 45 digits long. I never could—I always lost count before I got to the end. We have gone to Social Security. That seems to be something that most people remember now, but, obviously, we are going to have to build in something to the system to assure confidentiality because more and more people are getting ahold of your Social Security number, and I, frankly, don't want them to know what I have been treated for or what I am suffering from.

Chairman STARK. Thank you very much.

Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

I agree completely with the Senator that we can invent a whole series of numbers and thresholds, but all that does is invite talented people to begin to pursue how to crack the new numbers and the new thresholds. So to me it is not so much which number is selected, it is the protection surrounding the way in which the number is used. And that is why we, for simplification purposes, decided to go with a Social Security number.

Mr. Chairman, you have indicated that the Federal Reserve is a model that you are looking forward to emulating. We are going to have enough trouble in dealing with all of this area of health care. I hope you don't have an administrative model in the trilateral commission that you admire because, with some of the folks I am dealing with now, if we are going to have to buck the Federal Reserve and the trilateral commission I would much rather just focus on health care concerns.

Chairman STARK. If the gentleman would yield. He may have raised a scepter here that doesn't really exist. The Federal Reserve, in addition to its controversial open market and dealing with the gnomes of Zurich and all those sort of internecine things, handles a fairly routine, almost post office-like job of shuffling checks around the country and clearing them for other banks. It is pretty plebeian, but it does establish the standard to which all banks have to adhere so that the system works smoothly.

I didn't mean to——

Mr. THOMAS. I understand, Mr. Chairman.

Chairman STARK [continuing]. Intend that we get into the issue of independent Federal Reserve boards or open market, which I don't understand.

Mr. THOMAS. I sure hope not, but anytime it is mentioned I have a group of folk who begin writing me and telephoning me, and I would like to keep it on the issue of health care rather than the other one.

You also have examples in terms of the Social Security system shifting over to a model.

One of my big concerns is that I think, given the controversy that is going to surround this uniformity and questions of confidentiality and security and the rest, is that I think we may have one shot at getting it right if we adopt this system. And I don't know if we let the private sector—and I have looked at it from several different directions, Senator, and my question, ultimately, will be where your thoughts are on the matter. And have you looked at it?

And one model, obviously, would be to have the Federal Government set standards and let the private sector write a whole series of software approaches to that standard, and then whether or not they communicate would be somewhat iffy, a little bit like the IBM MS–DOS system and then the clones maybe sometimes talking with it a majority of the time but critical areas dropping out.

I have wondered, talking about MS–DOS, if it wouldn't be smarter for us to just go to somebody like Bill Gates and say, the system has been good to you. How about you folks come up with a software structure that does everything we have asked you to do? That is, have the government go to the private sector, let them offer a single software structure and then folks could look at different hardware structures that they would pay for.

My concern is that we agree to do it. We have a common goal. We charge some folks with it. And it doesn't quite work either in terms of integration or transmission or there is a breakdown somewhere. That is my greatest fear.

And if you have had any assurances that that shouldn't be, I would love to hear it. But it seems to me if we could get a single standard software that would be available to all rather than having the private sector develop several different systems of software to a standard, we might give us an even higher level of guarantee that the system will on day one be integrated, work, and do what we want it to do.

Senator BOND. I don't know about your degree of confidence in Murphy's law, but that is one that I have learned never to underestimate. And, frankly, I think that we establish some standards, perhaps the compatibility with the Federal payment system is the basic standard. I really believe that somehow the private sector has solved the problems in ATMs. ATMs have had some failures, and there are going to be some failures in this system because humans are designing it, and humans are going to operate it.

Frankly, if the government tries to establish one standard, it may be like the Japanese effort to establish analog HDTV which, fortunately, we did not follow. And by hook and by crook it looks like the United States' private-sector innovation has come up with something that will be the standard. I expect that from the private sector will come the solutions. If we build the field, they will come and play the game.

Mr. THOMAS. Final question. A number of folks have said we should wait until we go ahead and set up the new structure, what-

ever the new structure is, and then go ahead and simplify. My mind currently is that if we go ahead now we may make some savings in the system, but I think we will also learn a lot about what we need to do.

And if we do it in two stages, if that is necessary, the second stage will be better for it. We either save money or we have a learning curve that is useful on the second stage. Any reactions to when we do it?

Senator BOND. I concur completely. I wanted to get it done last year. I ran into the argument we have got to save it up and do it all at once.

Frankly, my view is there are so many questions in health care reform that there is no single, simple, silver bullet answer, and we better begin with first things first. Because, whatever direction we go, a good electronic data information system is going to tell us how the system is working and how to improve whatever we impose.

I hope we can take this as a first step because we are going to—we are not going to take them all at once in my humble opinion.

Mr. THOMAS. Thanks, Senator, very much.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman.

Mr. Chairman, I agree with all the speakers that of all the areas this subcommittee has held hearings on this is probably the one where we can extract some savings in the most painless fashion if, in fact, we get to work on it.

In response to Bill Thomas, there are systems already being developed and on line. And I mention that because I had the opportunity recently to view such a system that has been developed by a Wisconsin telephone company in conjunction with Ameritech. They are out there selling the package to hospitals, doctors offices and third-party payers of medical claims.

It is one which stresses confidentiality. There is a floating code where, if you were to access your own record and come back 5 minutes later to try to punch that same code, it would be changed. They have incorporated all sorts of little nuances to protect the security of the system.

And I think it probably would be wise, Mr. Chairman, at one point to have the folks come up and explain their system to this committee. It is being accepted by Wisconsin hospitals, and it encompasses the whole range of administrative services, from the admission of the patient to the billing of services.

For example, a doctor, prior to making his hospital rounds, goes to the office and punches up your name. The physician can get the vital signs, what transpired in the evening hours with the patient. So when the physician walks into the hospital he knows exactly what to expect.

And so I think we should view systems like that instead of remaking the wheel. Here is one area where we can possibly save some decent dollars.

On the question of what numbering system to use, I am not too keen about using our Social Security number for everything, but it seems that this might be appropriate. I have one concern. Assum-

ing we are not going to have a picture ID, since that would be quite difficult to keep updating every couple years, how would we prohibit unauthorized counterfeit use?

With the universal health care system it wouldn't really matter if your brother from Kansas came to Missouri and used your card, but if your cousin from Warsaw, Poland, came down, how do we protect that person not going to the emergency room or whatever and just using your card?

Senator BOND. Frankly, I am not an expert on those details, but I think we are developing technology which would allow things beyond just a PIN access, a thumbprint, a voice print. There are many things that people far smarter than I have developed that would provide additional identification and safeguard. I will leave that one up to the experts.

I like to Monday morning quarterback football and second guess the manager on bringing in relief pitchers, but I do not consider myself qualified to know what particular physical attribute would be most effectively utilized in conjunction with a card. I am sure we can find one.

Mr. KLECZKA. Fine. Thank you, Senator.

Mr. Chairman, again, let me indicate that I think it would be wise for the committee at some point to view this system. I found it most interesting and challenging and something that we could possibly look to as a model.

Chairman STARK. Thank you.

Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman.

Thank you, Senator, for your testimony.

One statement you made that I liked was if we build the field they will play on it. I assume you mean by we, the government, and they being the providers, the medical community. Assuming that we have to build a field for them to play on, what are we going to use to build that field? What are we going to do to facilitate the game?

Senator BOND. That is basically what I attempted to outline earlier as a board of government officials to establish the standards, the information, the data format. I believe, talking with the players in the field, that they recognize that for antitrust constraints and a lot of other reasons, competitive advantage, they can't do it themselves.

We provide for a board of government bureaucrats, and no one is more reluctant to do that than I. But I think in this situation we must do it, advised by a broader panel of experts in the field in the various disciplines related to provide them input and to count on the board coming up with a standard format that becomes the playing field. I just don't believe we can get everybody together communicating in the same language unless we have the standards that come with a government imprimatur.

Mr. MCCRERY. Well, thank you, Senator. I am sure there are some areas like antitrust that we will have to look at in order to facilitate this process.

I don't want to take up any more time, Mr. Chairman, with the Senator, but I appreciate your work on this, and I am sure it will be helpful to us as we go through this process.

Senator BOND. Thank you.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

Welcome, Senator. I want to pick up on an aspect of this issue that you referred to, but we haven't discussed.

We have discussed mostly billing issues, the standard card and the problems of carrying a medical history on that card. Applying information management technology to health care does really offer us an opportunity to accelerate the pace at which we integrate experience to create outcomes research and national guidelines.

That would require that we not only establish a standard claims form and a uniform data set for billing and record keeping but also for diagnostic and treatment purposes so that the experience in the use of a new technology would be recorded on the chart in a uniform but also depersonalized way. That issue came to my attention a couple of years ago when I included a provision along this line in a bill I introduced a couple years ago and has continued to interest me.

Now the privacy issues are quite different there and could be less, depending on how we structured that part of the computer program. But it does seem to me important that we be able to build a system that a physician in his office could chart into with symptoms, with treatment and then with outcomes and that just that portion of the information could be dumped into a national data bank so that, in a sense, as we use and experience new drugs and approaches and protocols we can also evaluate their effectiveness. Is that part of your proposal?

Senator BOND. Very definitely. I don't think we are going to get a good information on what works and what doesn't work. Our systems for gathering health care information are very, very rudimentary in many instances. And, while the administrative savings in claims, filing processing and payment are the first and most obvious savings, I think long term for health care information the ability to provide a common diagnostic report on the condition and the treatment and what comes out of it may provide some significant advances in the future.

Right now, by way of sidelight, I am working on legislation for getting information on birth defects, the number one killer of infants. I am pursuing a bill that is supported by the March of Dimes because the CDC doesn't have information.

A tragic situation occurred in Texas, and it was much after the fact that they finally realized there had been a large number of births of children with limited or no brain stem, and a good information system would have identified that early on.

Nobody has access to that information now, and I see there are tremendous possibilities. But we can make savings right now on the front end with the hope that there will be significant quality improvements in health care on the longer end.

Mrs. JOHNSON. Thank you, Senator. I agree with you absolutely. I appreciate your leadership.

Chairman STARK. Senator, thank you very much for your assistance today. We look forward to working with you as we try and put this issue to rest. Perhaps we can get this one done this summer while we are waiting for some of the other important issues in

health care reform to develop, and it is good to know of your interest. I am sure the committee will look forward to working with you over the months ahead. Thank you very much.

Senator BOND. Mr. Chairman, I appreciate the opportunity, and I thank you and the members of the committee for your leadership on this issue and assure you that we will do everything we can to work with you. Thank you.

Chairman STARK. Thank you very much.

Our next witness is Robert Reischauer, the Director of the Congressional Budget Office.

It is always a pleasure to welcome you to the committee, Bob, and your complete statement, which was accompanied by an even more complete statement, will appear in the record in its entirety. Why don't you proceed to give us the good news/bad news in any order that you wish.

STATEMENT OF ROBERT D. REISCHAUER, PH.D., DIRECTOR, CONGRESSIONAL BUDGET OFFICE

Mr. REISCHAUER. Thank you, Mr. Chairman and members of the subcommittee.

It is a pleasure to be here once again, this time to discuss the potential saving that might accrue from administrative simplification in our health care system. I will submit my prepared statement for the record, and in the next few minutes I will summarize CBO's estimates of the total administrative costs that are incurred by insurers and providers and the amounts that could be saved through various kinds of systemic reform of the health care system.

Overall, health care administrative costs in 1991 were estimated to be about $177 billion, or 23.4 percent of our national health expenditures. Of this total, $40.3 billion represented expenditures by insurance companies for such things as claims processing, marketing and underwriting, and $137.2 billion represented the costs incurred by hospitals and doctors that were not directly related to patient care.

The figure I just cited for insurance companies has been adjusted a bit from the official figures to smooth out the 6-year underwriting cycle that is characteristic of the insurance industry and to subtract premium taxes that are paid by insurers.

Of course, not all of the $137.2 billion in provider administrative expenses would be affected by administrative simplification. The only portion that would be is those costs that are associated with patient-specific financial accounting and billing. Our estimate of that portion for the year 1991 is about $31 billion or a bit over one-fifth of the total amount that providers spent on administrative costs. Thus, if you add the amount that I mentioned for insurers and this reduced amount for providers, you get a total of $71.3 billion, or 9.5 percent of national health expenditures, that might be affected by changing our system into a more simplified approach.

By how much could health care reform reduce this figure of $71 billion? That, of course, depends on the particular type of reform that we choose to pursue. A single-payer system with no deductibles or coinsurance and a system of providing hospitals with global budgets would generate the largest administrative savings

by our estimates, something on the order of $52 billion in 1991, or about 6.9 percent of national health expenditures.

Under such a system, the insurer would have no difficulty establishing eligibility because everybody would be eligible. There would be little, if any, need to coordinate benefits with other payers. Marketing and underwriting expenses would be eliminated. Medical professionals billing costs would fall dramatically because they would be submitting claims for payment to a single insurer and they would have no need to bill patients for any copayments. And, of course, hospitals and other institutional providers would only bill for amenities and would have little need to maintain patient-specific financial accounting systems. All of these changes together are what produce that rather dramatic saving in administrative expenses.

However, such a system would have to rely solely on provider controls to restrain the use of services, a drawback that could be overcome by a single-payer system that maintained patient-specific billing for hospital services and imposed copayments on patients.

But the administrative savings from such a system would be less than those from the Canadian-style system that I just described. They would be about 4.6 percent of national health expenditures, or roughly $34 billion, if we were talking about 1991 with this system fully implemented. The savings on insurance administration would be nearly as large as they would be under the Canadian-style system, but the savings on provider administrative costs would be only about 40 percent as large because the providers would still have the expense of billing both the insurer and patients.

Single-payer systems, however, have just discussed have the disadvantage of limiting consumer choice and reducing the insurer's incentive to innovate. An all-payer system in which multiple insurers adopted the same rates and the same payment policies would offer such diversity along with some simplification.

However, the administrative savings that could be garnered from such a simplified system would probably be rather small. We estimate them to be only about two-tenths of 1 percent of national health expenditures or a bit less than $2 billion, in terms of the change in 1991.

Essentially, no saving on insurance administration would accrue because insurers' expenses for marketing, underwriting, and coordinating claims would not change significantly from the situation that we have right now. Instead, these costs would be somewhat higher because use of services would probably increase. Billing-related costs for providers would fall by about 15 percent from current levels because uniform payment rates and policies for insurers would simplify the claims process somewhat.

So the bottom line here is that administrative savings from a reformed health care system could range from being quite substantial to being rather minimal, and, as Ross Perot said, the devil is in the detail. It all would be determined by how one answered a lot of very specific questions.

Let me conclude with several cautions about the numbers that I have just provided.

The first is that these estimates may, in fact, overstate somewhat the savings from a simplified system. There is already, as you have been discussing before, a move underway to pursue electronic billing using standardized claim forms, and that movement will realize some of the savings that we have included in our estimate.

My second caution is that while there is a good deal of uncertainty surrounding all of the estimates that CBO and others have provided for the potential savings from administrative simplification, a review of the literature of the last 5 years suggests that estimates of administrative savings have been falling as various researchers have refined their methodology. So, in a sense, these aren't numbers that you can take to the bank with you. They are numbers that should be used with caution. It is conceivable that, as we and other researchers refine our methodology for estimating administrative costs and the type of costs that might be affected by various sorts of reforms, the savings could, in fact, be somewhat smaller.

Finally, I think it is important to remember that while administrative savings are important they are only one of many features to consider when you evaluate a simplified system for providing health care in America, and they might be a rather insignificant one when compared with some of the other dimensions that have been under debate.

That concludes my summary. I will be glad to answer any questions the subcommittee might have.

Chairman STARK. Thank you.

[The prepared statement follows:]

STATEMENT OF ROBERT D. REISCHAUER, DIRECTOR, CONGRESSIONAL BUDGET OFFICE

I appreciate the opportunity to discuss the potential savings that might accrue from administrative simplification in the health care system. This issue has generated considerable interest because administrative costs are one factor accounting for the relatively high per capita costs of health care in the United States. Critics believe that these costs are unnecessarily steep, related in large part to the complexity created by a system with many payers. Under the current system, insurers must establish eligibility for each claimant and must often coordinate benefits with other insurers. Providers, in turn, must submit claims to many different insurers, each imposing a different set of requirements.

This statement presents estimates of what insurers and providers currently spend for administration. It also gives Congressional Budget Office (CBO) estimates of the amounts by which such expenses might be reduced under simplified systems. It draws on a staff memorandum, "Single-Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates," that CBO prepared in April 1993 for this Subcommittee.

Let me note several caveats about these estimates. First, they are for calendar year 1991, and they assume that the simplified systems were fully effective throughout that year. Second, the transitional costs of moving from the current system to a new one are not included. Third, they are not CBO cost estimates, which relate to specific bills and depend heavily on detailed legislative language. Finally, though administrative savings are important, they are only one of many features to consider in evaluating a simplified system.

BACKGROUND

Administrative (or overhead) costs in the health care system take two forms--costs for insurers that are reported separately in the National Health Expenditure (NHE) Accounts, and costs providers of care incur that are not shown explicitly in the accounts. The administrative costs of providers are a component of the amounts spent for specific services, such as hospital care. Various analysts have estimated these costs in different ways.

For 1991, the costs of administration reported for insurers totaled $43.9 billion, or 5.8 percent of national health expenditures. These costs include expenses for marketing, underwriting, and claims processing, as well as amounts retained for reserves and profit.

CBO made two adjustments to the reported figures. The first adjustment was to correct for the six-year underwriting cycle characteristic of health insurance, in which insurance companies tend to build reserves for about three years and then deplete them for the next three years. To smooth these cyclical effects, the administrative expenses of insurers, as a share of insurance benefits, were averaged for 1986 through 1991. CBO then applied this average to the value of insurance benefits in 1991. The second adjustment was to subtract premium taxes of about $1 billion paid by insurers, because they are not inherent costs of insurance. Thus, the adjusted administrative costs were $40.3 billion, or 5.4 percent of similarly adjusted national health expenditures (NHE/A).

If one considers only hospitals and physicians, the costs of administration for providers in 1991 are estimated at $137.2 billion, or about 18 percent of national health expenditures. For hospitals, estimated costs are $93.9 billion, including all expenses not directly related to patient care for personnel, buildings, equipment, supplies, and services. For physicians, estimated costs are $43.3 billion, again including all expenses not directly related to patient care--nonmedical personnel, rent, office equipment, supplies, and services.

Administrative simplification, however, would affect only that portion of providers' costs related to patient-specific financial accounting and billing. CBO's estimate of this portion of the administrative costs of providers for 1991 is about $31 billion, or 4.1 percent of NHE/A. Thus, the total that administrative simplification might affect, including costs for both providers and insurers, is $71.3 billion, which accounts for about 9.5 percent of NHE/A.

WHAT ARE THE POTENTIAL SAVINGS FROM ADMINISTRATIVE SIMPLIFICATION?

From an administrative standpoint, the simplest approach currently under consideration would be a Canadian-style single-payer system (SP2) with no deductibles or coinsurance. Under such a system, everyone would have first-dollar coverage from the same insurer. Consequently, the insurer would have no difficulty establishing eligibility, and there would be little if any need to coordinate benefits with other payers. Further, the marketing and underwriting expenses that make up a substantial part of the administrative costs for private insurers under the current system would be eliminated. Physicians and other medical professionals would submit claims for payment to a single insurer, with no need to bill patients for copayments. Hospitals and other institutional providers would receive annual budgets from the single payer. They would have little need to bill at all (only for amenities) or to maintain patient-specific financial accounting systems.

Under a Canadian-style single-payer system, total administrative costs would be about one-quarter of current costs, a reduction equal to 6.9 percent of NHE/A (see Table 1). This estimate takes account of the additional administrative costs associated with the higher use of services that would occur under a system with universal first-dollar coverage. In 1991, the savings would have been about $52 billion, nearly evenly divided between insurers and providers. To capture these savings for the taxpayer, though, it would be necessary to reduce payment rates to providers by the amount of their savings on administrative costs.

A system that did not require copayments from patients, however, would have to rely solely on controls on providers to restrain use of services. This drawback could be overcome under a system that involved patient-specific billing for hospital services (instead of annual budgets) and that required copayments from patients. Patient-specific financial accounting systems for hospitals can foster more cost-effective and higher-quality care. Moreover, health care costs are lower when copayments are required from patients because they use fewer services. This kind of system, though, would have higher administrative costs than a Canadian-style system.

Under a single-payer system with copayment requirements (SP1), total administrative costs would be about half of what they are under the current system, reducing NHE/A by about 4.6 percent, or $34 billion in 1991. The savings on insurance administration would be nearly as large as under SP2. Compared with the Canadian-style system, administrative costs would fall because use of services would be lower, but these savings would be offset by the administrative costs of a residual Medicaid program that would cover the copayment liabilities of low-income people. By contrast, savings on the administrative costs of providers would be substantially lower because providers would have the expense of billing both the insurer and patients.

TABLE 1. ESTIMATED CHANGES IN SPENDING FOR ADMINISTRATIVE COSTS, 1991 (In billions of dollars)

	SP2	SP1	AP2
Providers			
Actual	31.0	31.0	31.0
Estimated	5.9	21.2	26.6
Change	-25.2	-9.8	-4.4
As a Percentage of NHE/A	-3.4	-1.3	-0.6
Insurers			
Actual	40.3	40.3	40.3
Estimated	13.5	16.0	43.1
Change	-26.8	-24.3	2.8
As a Percentage of NHE/A	-3.6	-3.2	0.4
Total			
Actual	71.3	71.3	71.3
Estimated	19.3	37.2	69.7
Change	-52.0	-34.1	-1.6
As a Percentage of NHE/A	-6.9	-4.6	-0.2

SOURCE: Drawn from Congressional Budget Office, "Single-Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates," Staff Memorandum (April 1993).

NOTES: SP2 = Canadian-style single-payer plan; SP1 = Single-payer plan with copayment requirements; AP2 = All-payer plan without universal coverage; NHE/A = Adjusted national health expenditures.

The CBO memorandum also examines an all-payer plan with universal coverage (AP1).

Single-payer systems, however, would have the disadvantage of eliminating consumer choices about benefit packages and sources of coverage. With multiple insurers, consumers have some choice in these areas, giving insurers greater incentives for service and innovation than might exist under a single-payer system.

One form of multipayer system that could achieve some administrative simplification is an all-payer system--under which multiple insurers would all adopt the same rates and policies for payment. In such a system (AP2), savings on administration would be small, only about 0.2 percent of NHE/A, or $1.6 billion in 1991. Essentially no savings on insurance administration would accrue because insurers' expenses for marketing, underwriting, and coordinating claims would not change significantly; instead, these costs would be somewhat higher because use of services would increase. Billing-related costs for providers would fall to about 85 percent of current levels, assuming that uniform payment rates and policies for insurers would simplify the claims process somewhat. Overall, total administrative costs would be about 98 percent of current levels.

Potential savings from simplified systems in later years, however, might be overstated by the estimates in Table 1 because of the move to electronic billing using standard claims forms that is already under way. According to a 1992 report from the Administration's Workgroup for Electronic Data Interchange, electronic billing might cut costs for both insurers and providers under the current system by $4 billion to $10 billion when fully in place. That shift would somewhat reduce the potential for further savings from simplification.

HOW DO CBO'S ESTIMATES COMPARE WITH OTHERS?

Although CBO's estimate of potential savings on administrative costs under a Canadian-style single-payer system is smaller than those in most other recent studies, the differences are not large (see the fourth column of Table 2). In the case of insurance administration, the differences stem primarily from the relatively minor adjustments CBO made to current costs (for the insurance cycle and premium taxes) and from different assumptions about whether private supplementary insurance and certain public health programs would continue. For example, the other estimates assumed that private insurers would cover some services not covered by the single payer, while the CBO estimate does not. For providers' administrative costs, the differences primarily stem from CBO's assumption that certain services, such as those provided by long-stay hospitals, would be financed outside the single-payer plan, and that administrative simplification would affect only billing costs.

Although administrative costs would be lower under a Canadian-style system, total spending on health might be higher. CBO estimates that national health expenditures would increase by 5 percent if the system had no explicit spending caps. Estimates by others suggest smaller increases or even decreases. The primary reason for this difference is that CBO's estimate of the increase in use of services under a system of universal first-dollar coverage is larger than was assumed in the other studies. CBO's estimate of the overall effects would be even larger (an increase of about 7 percent) had it assumed--as did the other studies shown in Table 2--that average payment rates for providers would be unchanged under the single-payer system. Instead, CBO's assumptions imply that average payment rates for physician and certain other services would be about 13 percent lower, while average rates for hospital services would be unchanged.

CONCLUSION

A good deal of uncertainty surrounds the potential savings that might be achieved with administrative simplification. CBO's estimates suggest that earlier attempts to gauge the magnitude of these savings might have been too optimistic. A review of the literature on this topic shows that estimates of the potential administrative savings have tended to fall each time the methodology for estimating was refined.

Nevertheless, potential savings from administrative simplification are appreciable. Administrative costs that might reasonably be affected by simplification amount to nearly 10 percent of national health expenditures. CBO estimates that administrative costs might be reduced by nearly 7 percent of health spending (or by $52 billion in 1991) under a Canadian-style single-payer system. Potential savings in later years might be somewhat less because administrative costs may be relatively lower anyway as a result of the ongoing move to electronic billing. The administrative savings that might be achieved under other systems--such as a single-payer system with copayment

requirements or an all-payer system--would be smaller. However, these alternative systems would offer other advantages that might warrant their higher costs of administration. Administrative costs are only one of many factors to consider as the Congress debates modifications to the current health care system.

TABLE 2. COMPARISON OF CBO AND OTHER ESTIMATES OF SPENDING CHANGES UNDER A CANADIAN-STYLE SINGLE-PAYER SYSTEM, AS A PERCENTAGE OF NATIONAL HEALTH EXPENDITURES, 1991

Study	Changes in Overhead Costs for: Insurers	Hospitals	Physicians	Total	Newly Induced Spending	Overall Change in National Health Expenditures
GBHW[a]	-3.8	-4.4	-1.3	-9.5	1.7	-7.8
GAO[b]	-4.6	-2.5	-2.0	-9.1	8.7	-0.4
SYR[c]	-3.0	-1.8	-1.5	-6.4	10.6	4.2
CBO[d]	-4.2	-1.8	-1.1	-7.1	12.2	5.0

SOURCE: Congressional Budget Office.

NOTES: The CBO estimate assumes that average payment rates for physician and certain other services would be reduced by about 13 percent, while average rates for hospitals would be unchanged. The other estimates assume that average payment rates would be unchanged for all services.

These estimates do not include the effects of cost containment provisions--such as effective expenditure caps or price and utilization controls--that are in some recent proposals.

a. K. Grumbach, T. Bodenheimer, D. Himmelstein, and S. Woolhandler, "Liberal Benefits, Conservative Spending: The Physicians for a National Health Program Proposal," *Journal of the American Medical Association*, vol. 265, no. 19 (May 15, 1991).

b. General Accounting Office, *Canadian Health Insurance: Lessons for the United States* (June 1991).

c. J. Sheils, G. Young, and R. Rubin, "O Canada: Do We Expect Too Much from Its Health System?" *Health Affairs*, vol. 11, no. 1 (Spring 1992).

d. Congressional Budget Office, "Single-Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates," Staff Memorandum (April 1993).

[An attachment, "CBO Staff Memorandum: Single-Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates," is being retained in committee files.]

Chairman STARK. I gather by your closing comment that you are referring to the secondary benefits that we might get from a data collecting process that would allow us to have some more empirical research on costs and the whole study of the health care delivery system as a type of benefit that might be a collateral benefit out of simplification or data processing standardization. Is that the direction you were heading?

Mr. REISCHAUER. Yes, I think that will be terribly important. But, once again, the fruits of that are likely to take a good number of years to ripen.

Chairman STARK. Not necessarily a savings——

Mr. REISCHAUER. No, not savings, an improvement in the quality of care that Americans receive.

Chairman STARK. Let me try just a hypothetical because I have trouble sometimes with the terminology.

When you talked about the $31 billion to providers—and I don't want to prejudice this. Let's assume that everybody had Blue Cross low option or had that level of benefits and that everybody—every hospital and physician—were reimbursed in the manner that Blue Cross reimburses using one format but that each hospital, similar to Maryland, had a different rate.

Now this seems to me to not be a tricky system for electronic data processing to handle. Would that have almost the same effect as a single-payer system if you had an all-payer system and in terms of the savings we could achieve or does that——

Mr. REISCHAUER. The $31 billion I referred to was the total amount that the providers are spending on keeping patient-specific financial records and on billing. You couldn't eliminate that entirely, even with a single-payer system without any copayments and with global budgeting, because the provider would still have to——

Chairman STARK. What I have often heard is the kind of statement, although the hospitals have been willing to split the difference, that if we had a Canadian system—and I am not suggesting it—we could get rid of one clerical employee per hospital bed. Some of the larger hospitals will say, maybe half an employee per bed. They might agree in that now the hospitals have to keep whole computer systems to figure out whether one or two or three insurance companies is going to pay the bill, and each insurance company pays a different amount of it.

If that were all eliminated and were eliminated in the doctor's office so the hospital or the doctor didn't have to figure out how much they were going to get paid, if that was not their worry, if they just put the number in the terminal, and they would get paid whatever the agreement is under whatever system it is, would that be the type of system that would get to your $31 billion?

Mr. REISCHAUER. By our estimate, the numbers that I have in my testimony suggest that that would save something on the order of $10 billion in 1991. I am just talking about the provider part of that, not the insurer element, but provider costs would fall in 1991 by roughly $10 billion if we had a system like that.

Chairman STARK. And then the rest of the 20 would come out of the insurance part of it?

Mr. REISCHAUER. No, it is not possible to save the whole $31 billion. That is the total amount that providers spent in that year for these types of activities.

Chairman STARK. So you think——

Mr. REISCHAUER. The most we suggest that you could save out of that $31 billion would be from a Canadian-style system in which hospitals were under a global budget, physicians were reimbursed from a single insurance company, and there were no copayments, so all they had to do was send the paperwork into that single insurer. In that case, $25 billion of the $31 billion could be saved. That would be 3.4 percent of national health expenditures which is very substantial.

But as soon as you go to a system in which there have to be copayments and there is patient-specific financial data kept in the hospitals, the savings decline very rapidly.

Chairman STARK. You noted the difference between your analysis in your April report and actual cost estimates of savings that might be attached to specific legislation. Would the legislation have to force providers to accept reduced revenues for you to score it for us? Would we have to specifically force the reduction?

Mr. REISCHAUER. Well, if you instituted various kinds of simplifications but then didn't have a mechanism for lowering rates, obviously, the first reaction would be for providers just to increase their profit margins or to provide more amenities or whatever. This really gets down to an issue of the extent to which you think competitive pressures work in the health care area over the long run. I think there is some competition even in the system that we have now, and over time some of the savings would accrue to patients in the form of lower costs, but it might take a good deal of time to wring out that those excess profits.

Chairman STARK. Which would be easier for you to estimate?

Mr. REISCHAUER. Oh, the first option would clearly be easier to estimate and more certain.

Chairman STARK. Thank you.

Mr. Kleczka.

Mr. KLECZKA. I have no questions.

Chairman STARK. Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

We have in front of us an examination of a single-payer and an all-payer health insurance system using Medicare's payment rates. How did we wind up studying the single-payer and all-payer model?

I will answer it for you. Wasn't it a request by the Chairman of this subcommittee to have you look at this particular model?

Mr. REISCHAUER. We were asked to look at this issue by a number of committees. These are purely generic examples of reform. They are, in a sense, extreme options.

Mr. THOMAS. I understand that, but in terms of your analysis, did you go beyond the numbers, for example, that are presented in the Canadian model to try to determine if there were any actual hidden costs that were not evident in the numbers or did you just take the basic usual numbers and compare them?

For example, last week we were talking about costs. Now you can take an automobile accident, for example, a two-car accident in the

middle of the 14th Street bridge, it costs what it costs to fix the cars because of that accident. Those would be easily discernible numbers, and you would then publish them. I think in part that is what you have done with this.

What about all those cars—since there is a penchant here in Washington that there seems to be an unwritten rule that when you are hit you have to leave the cars where they were hit. Even if it is in the middle lane of the bridge, you don't push them off to the side. Don't you also think it would be fair to attribute the lost work costs of all those people that were delayed behind those cars needlessly or unnecessarily had there been a different system and that those are just as much real costs as the fixing costs? Is that a fair estimate?

Mr. REISCHAUER. I certainly agree with you. I think if you read our report and my testimony, I point out that there are these other dimensions and that administrative costs are not total dead weight loss. Some administrative costs, obviously, are associated with furthering managed care and utilization review.

Mr. THOMAS. I also have a problem with patients in terms of wasted time for patients. That may be part of a system that is inherent in this kind of a structure, that aren't figured in, that could balance off. I am just aware of a number of studies that look at so-called hidden costs in these kinds of structures, and I am wondering if you took any of those considerations into effect when you determined the relative cost structure of the two systems.

Mr. REISCHAUER. These were estimates of what happens to national health expenditures, not the total economic impact of reform.

Mr. THOMAS. But don't you think that a study along those lines—and I have very limited time—don't you think a study along those lines may provide useful numbers but certainly that, oftentimes, the hidden costs or the real economic costs if we are going to make a fundamental change in the system ought not to be examined?

Mr. REISCHAUER. I agree with you, and I think those aspects have been reflected in the studies that we have done. We have not done studies trying to estimate the size of those costs, but at every relevant point we have turned attention in that direction.

Mr. THOMAS. Well, my concern is that, especially without proxies, this subcommittee would not vote for a single-payer model. The President has rejected the single-payer model. Have you examined the current U.S. system in terms of the real cost to the system on the basis of tax and regulatory factors, both at the State and the Federal level? That if we simplified those or went to some of the administrative changes, the actual savings that we would have in that regard?

Mr. REISCHAUER. No, we haven't.

Mr. THOMAS. And primarily because you haven't been asked?

Mr. REISCHAUER. Also, because it is an immensely complicated task that would take a very long time to do.

Mr. THOMAS. So what we have in front of us is a study done because it is easy to do and you were requested to do it, even though it may not reflect any really meaningful numbers on a comparison between the United States and a single-payer system like Canada.

I would very much like to task you with what I consider to be a more valuable job, and I am sure this administration would as

well, and that is look at our current structure, what are the costs of the regulatory and the taxing structures that we have and how can we streamline and simplify that under something other than a model which we are not going to have available to us as a real option despite the wishes of a number of folks?

Once again, thank you very much for your testimony.

Mr. REISCHAUER. I would also say, this is only one of many reports that we have done. We are doing or have done other reports that address some of the issues I think you are concerned with.

Mr. THOMAS. Although it is complicated, I do think maybe we need to sit down and task you with some aspects that I think would be useful for us as we share this administrative cost simplification model so that, as we get criticisms, we can at least agree with them or perhaps begin to disagree because we are getting a handle on the price. It will be difficult, it will be complicated, but it seems to me the information would be at least as useful as a study of a single-payer system which doesn't take into consideration all of the economic costs people are faced under that system in an attempt to determine whether or not this would be a model that some people would argue we should follow.

Mr. REISCHAUER. Let me suggest that the usefulness of this rather limited study and the testimony that I have given is to put a realistic bound on the administrative savings that might come from radical reform. If you recall, several years ago numbers were bandied about in Washington and before this subcommittee that a simplified system of the Canadian sort would save over $100 billion. One reason we were asked to look at this issue was to determine how realistic are those numbers?

I am giving you a set of numbers that are half as large as the estimates that were provided several years ago. I think——

Mr. THOMAS. All I am saying, Dr. Reischauer, is have we looked at it from what I consider to be a more realistic view? You have the numbers. Perhaps we would half them again or perhaps there are no real savings to be found at all. It just seems to me we are moving in the right direction.

Mr. REISCHAUER. OK, thank you.

Chairman STARK. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman.

There is no question that it is very difficult for you or your organization or anybody else to estimate with any confidence the savings from various reform, administrative reform proposals. But certainly I think—I would hope you would agree that it is safe to say that, with some administrative simplification, there are savings to be had in the system. Where those savings would poke out, whether in increased profits or in savings for premiums or whatever we don't know, but there would be some savings, right?

Mr. REISCHAUER. There would be, but the size of those savings would depend on the exact nature of the reform. Some of the types of reforms that people are talking about would generate relatively small amounts of savings in terms of national health expenditures. They might produce much more efficacious care. They might produce much more rapid reimbursement of providers. They might provide the data system that we need to do some sophisticated

types of research on what treatments are efficacious and so on. So there are a lot of nonmonetary dimensions to this issue.

Mr. McCrery. But bottom line, I mean, there is no reason that you can think of why if we can identify some administrative simplification measures that make sense we shouldn't go forward with them?

Mr. Reischauer. Correct.

Mr. McCrery. OK.

When I visit physicians in their offices or visit hospitals, it seems that the thing that always pops up is the administrative hassle connected with the Medicare system. Now, that is a Government-imposed cost on the system, something that I would hope your office and our committee would be concerned with. Have you all looked at the cost to the system of the governmentally imposed quality assurance regulations?

And the most—one of the most common complaints I get from doctors is, dad gum it, I sent the form in. It was all filled out. And because I stamped the date on the left hand corner instead of the right hand corner, they sent it back to me, so I had to have a nurse go ahead and fill out a completely new form and send it back in. That kind of junk. Have you all looked at that? Do you have any cost estimate?

Mr. Reischauer. No, we haven't. I think that is the kind of thing that would more appropriately be examined by GAO and by HCFA. We don't have the resources to do that kind of fieldwork, which is what would be involved.

Mr. McCrery. What is the process? Would they examine it and then give it to you for a cost estimate that we could score?

Mr. Reischauer. What you are suggesting is that the current system is inefficient in some ways, and through either a relaxation of requirements that aren't particularly critical to the functioning of the program or through some kind of new mechanism or billing we could save resources. What I am saying is that we just don't know what is wrong beyond anecdotal reports such as yours. I mean, maybe there is evidence that quantifies this, but until that evidence is available my office would have a difficult time coming up with an estimate of the savings that might result.

What it sounds like is that the savings that would result would be in the provider's office. The actual administrative expenses of the Medicare system from an insurer's standpoint are relatively low and compare favorably with the administrative costs of the Canadian system, but this isn't counting the imposition of costs on the providers.

Mr. McCrery. Mr. Chairman, I would hope that this committee would ask HCFA or GAO or somebody to get that information to CBO so they could give us some estimate of the savings that we might get on the government side from administrative reforms or maybe even from doing away with some of the quality assurance measures that some providers think provide little quality assurance but a lot of hassle and a lot of cost to the system.

Chairman Stark. The gentleman's suggestion will be considered. Mrs. Johnson.

Mrs. Johnson. Thank you, Mr. Chairman.

In my time, Mr. Reischauer, I want to try to clarify what I think you are trying to say in your testimony, and then I have two short questions I would like to leave time for at the end.

On page 4 of your testimony, after pointing out that the total amount of administrative costs that might be affected by administrative reform is $71 billion, you claim in the last line of page 4 that reform could save $52 billion. However, in the sentence before that you point out that this estimate takes into account the additional administrative costs associated with higher use of services. Does this $52 billion estimate take into account the cost of that higher use of services and, if not, what is the offset? What are the expected increased use in services from going to the very simple administrative system of the Canadian-style system and what is the dollar offset against the $52 billion savings that we ought to keep in mind?

Mr. REISCHAUER. We included the answer to your question on page 9 of my testimony. Under the Canadian type of system, there would be a reduction in administrative costs, but there also would be newly induced spending from such a program because we would have universal coverage with no copayments. And so, under that particular variant, total national health expenditures would go up by 5 percent—in other words, more than offsetting the administrative savings.

Mrs. JOHNSON. OK. So we would save $52 billion, but that would be more than offset by the increased use of services. Am I hearing you right?

Mr. REISCHAUER. Yes.

Mrs. JOHNSON. Thank you. I think that is very, very important because these reports are out there quoted as saying administrative simplification, the Canadian-style administrative plan, would save us $52 billion. When you look at it in the context of our health care service sector, it would actually increase costs 5 percent, correct?

Mr. REISCHAUER. Under the set of assumptions we used, that is correct.

Mrs. JOHNSON. Now, the second thing I want to ask goes to my friend and colleague, Mr. Thomas's question.

You did estimate for me the savings across the board of a totally managed care system for simplification purposes, and for all those things we used a staff model HMO to get that estimate. And the estimates in that report were the same as the savings for a single-payer system. Administratively, what would be the savings in that kind of system and what would be the ability to control the increase in services in that kind of system? In other words, what would be the analogue for your $52 billion figure and your 5 percent total cost increase figure in a national HMO structure?

Mr. REISCHAUER. I don't have those numbers but will provide them to you for the record and for your own use.

Mrs. JOHNSON. Yes, I would appreciate that because I think that is very relevant, those two figures.

[The following was subsequently received:]

For CBO's managed care report. We developed estimates of the change in personal health care expenditures that the cost containment mechanisms inherent in HMOs might eventually generate. But we did not report the change in administrative esti-

mates I discussed today show changes not only for personal health care expenditures but also for administrative costs, compared with the current system.

I understand how useful it would be to have comparable estimates for administrative costs under a managed care system. Unfortunately, because of the great difficulty in completely separating administrative from personal health care costs in managed care systems. we have been unable to estimate separately the change in administrative costs that might occur under such a system. Our estimates for the managed care paper that we prepared earlier implicitly assumed that the overall change in administrative costs would be zero. The reason is that some factors might cause these costs to rise, while others might cause them to fall, and we are unable to quantify them.

Mr. REISCHAUER. A staff model HMO would, I think, have some success in restraining the use of resources, whereas the estimate that we have provided in this testimony reflects an unrestrained system. There are no global caps or other volume restraints placed on providers.

Mrs. JOHNSON. Great. You do note in your own testimony that if you go to a system of copayments you don't save as much money but you do constrain services some. But we all know that copayments are a primitive approach to service constraint and that the private sector has gone way beyond copayments now in trying to assure that the kinds of services provided are the kinds of services that are in harmony with outcomes research.

So then my last question is, do you have any information about the impact on administrative costs of these reforms if excluding from that definition of administrative costs we drop any consideration of underwriting costs or marketing costs?

I will tell you why I want to know that. If we reform insurance, we can radically reduce and I think functionally eliminate underwriting costs. And if we go to an individual mandate so that everyone has to have insurance and a sort of HIPC-style bureau, we can eliminate marketing costs. So I would like to know if, given a health care reform structure that say reduce by 90 percent underwriting and marketing costs, then what would be the administrative saving? Because I believe that your administrative savings is generated primarily from some of those sectors because they are the big buck sectors so that they have to be——

Mr. REISCHAUER. Our estimate of underwriting and marketing costs in 1991 was that they amounted to about 40 percent of administrative costs for private insurance.

Mrs. JOHNSON. The marketing costs alone.

Mr. REISCHAUER. And underwriting.

Mrs. JOHNSON. Marketing and underwriting of the $71 billion.

Mr. REISCHAUER. Of the private insurers' portion of the administrative costs. In other words, about $14 billion.

Mrs. JOHNSON. $14 billion of the $71 billion?

Mr. REISCHAUER. Well, no. If we just look at private insurers' administrative costs, they would be about $35 billion, so $14 billion is a substantial portion—40 percent—of the insurers' share of administrative costs. You are right.

Mrs. JOHNSON. Right. And so if we could see how much that would cut down the $71 billion there for the impact and the $52 billion, that would be useful. Thank you very much.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Grandy.

Mr. GRANDY. Thank you, Mr. Chairman.

Dr. Reischauer, are you familiar with the Work Force on Electronic Data Interchange that was set up last year, I believe, or perhaps 1½ years ago? When Louis Sullivan was the Secretary of HHS there was a Work Force on Electronic Data Interchange, and the estimate that came out of that working group was between $4 and $10 billion of savings if we went to that kind of completely harmonized network. Have you used that at all in any of the data that you have compiled to make these studies?

Mr. REISCHAUER. No. What I mentioned in my testimony is that the numbers that I have provided might be overstated because we have this effort going on already. Even if we leave our current system unchanged, to the extent that we go down that road and implement these types of reforms, we are going to get some savings in administrative costs that then won't be there to be saved under a simplified system. And I believe some of the other witnesses today are going to update those numbers and provide you with even larger——

Mr. GRANDY. I would assume. So I was just wondering, then, in the number that you give us of potential savings you are not necessarily adding that money that comes from the streamlining of the electronic data interchange that would supposedly, in the best of all possible works, link up hospitals?

Mr. REISCHAUER. In a sense, that would be a component of this——

Mr. GRANDY. OK, that is what I wanted to know.

Mr. REISCHAUER. Of this system. So what I am doing is something different than what Senator Bond did. What I am basically doing is asking, if we reform the health care system in one of these generic ways so that it isn't a system with 1,500 insurers and thousands of providers, each charging their own rates and having their own system, but is a more simplified system, how much administrative savings could we get?

Mr. GRANDY. Well, pursuing——

Mr. REISCHAUER. But we are making progress, even under our complex system, in streamlining things.

Mr. GRANDY. Well, speaking of streamlining, last week we had a hearing on malpractice reform and this week we are having a hearing on administrative reform, but it seems to me there could be a clear nexus between the two if you have an electronic data network where hospitals can access diagnostic advice that they otherwise would not get and that doctors would have some kind of an electronic database that would follow them from place to place and monitoring physician negligence or a pattern of practice.

It seems to me—what I am getting at is there is a nexus between administrative reform and malpractice savings. Would you agree? It is not something that I think you can score. I am not asking you in your capacity as head of CBO to say is this something that you could crunch in your office, but it seems to me that if you get to a kind of harmonized network of information——

Mr. REISCHAUER. The information you have in a fully elaborated electronic system of the sort that you are talking about would make it easier to monitor utilization and diagnostic procedures to make sure that providers were operating with the best practice, the best knowledge in mind.

Mr. GRANDY. But that could reduce the amount of defensive medicine, and there would be savings there I would think.

We are speculating about a health care system we haven't quite agreed on yet, but it seems to me that there is clearly a connection between this week's hearing and last week's hearings in terms of savings ultimately.

Mr. REISCHAUER. I think you would be more likely to get an improvement in the quality of care that Americans are receiving than large reductions in the costs of that care. That is speculation on my part, and——

Mr. GRANDY. Well, you have also to go back to something that Mrs. Johnson was talking about in her questioning. You said that you believed that, obviously, the more you have increased copayments, the more you probably reduce costs because they are more cost effective and produce higher quality, but you have also stated that they probably increase costs on the administrative side.

The data that you use to make that assertion, I assume, is based on Medicare and public programs like that, isn't that true? I mean, when you made that assertion in your testimony, on what basis do you make that assertion?

Mr. REISCHAUER. Well, when patients are faced with having to pay a portion of the costs, they voluntarily reduce the amount of services they demand. That reduces overall utilization. It makes the system more complex because the provider has to bill both the insurance company and the patient, as is the case now.

Mr. GRANDY. Would deductibles work better then?

Mr. REISCHAUER. Deductibles make things even more complicated.

Mr. GRANDY. So, in other words, it is not a question of copayments or deductibles decreasing administrative costs. They both would increase them in your view?

Mr. REISCHAUER. Yes.

Mr. GRANDY. Because it requires reporting.

Mr. REISCHAUER. Yes.

Mr. GRANDY. OK. Thank you, Mr. Chairman.

Chairman STARK. Now is your chance. Are there any other questions while we have Mr. Reischauer here?

If not, Bob, thank you very much for your help in this matter. We look forward to more visits with you in the future.

Chairman STARK. Our next witness is Carol Walton, the Director of the Bureau of Program Operations in the Health Care Financing Administration.

Ms. Walton, welcome to the committee. Your prepared testimony will appear in the record in its entirety. You might like to summarize it for us or expand on it in any way you are comfortable. Proceed.

STATEMENT OF CAROL J. WALTON, DIRECTOR, BUREAU OF PROGRAM OPERATIONS, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. WALTON. OK. Mr. Chairman and members of the subcommittee, I am pleased to be here today to discuss the Medicare trans-

action system, or MTS, and the role it will play in administrative simplification.

In 1992, HCFA's 80 Medicare contractors processed almost 650 million claims at more than 60 separate sites across the Nation. By 1997, that number will grow to over 1 billion claims.

We believe future contractor budgets will continue to be challenged by limited funding and increased work loads. New information systems technologies can reduce processing costs and the complexity of Medicare administrative processes.

One of HCFA's basic missions is to ensure that Medicare claims are processed in a timely, accurate and cost-efficient manner. In the past, HCFA has contained the administrative costs through increased automation of contractor systems and encouraging providers to file electronic claims.

In the 1980s, advances in technology led HCFA to initiate a more organized approach to systems development. This approach led to what we call the shared system and common working file initiatives. This initial step was to reduce the number of claims processing systems used by contractors through a shared systems policy. The current 15 systems resulted from that policy.

In 1990, we implemented the common working file or CWF, HCFA's first use of a single, national standard software system. The CWF serves as a check to ensure that Medicare's basic eligibility and other requirements are met. All Medicare claims are now processed through the CWF before payment is made.

Over the past 2 years HCFA has worked to transform Medicare billing to an all-electronic environment. The most updated numbers that I was just given this morning show that intermediaries are currently receiving 88 percent of their claims electronically and carriers are receiving 62 percent of their claims electronically. Congress can help us improve this level by extending the separate payment time frames for paper and electronic claims.

Last September, HCFA announced an initiative to meet the claims processing challenges that will confront Medicare in the coming decades. The Medicare transaction system, or MTS, will replace the 15 claims processing systems used at the 60 processing sites with a single uniform system at an optimal number of sites across the country.

MTS will be managed by the Federal Government but will be developed, maintained and operated by private contractors. Implementation will begin in 1996. Start-up costs will be fully recovered by 1998. The MTS will lower the overall cost of claims processing while improving service to both beneficiaries and providers because changes will have to be programmed only once rather than many times at many separate sites. The design will support a variety of transactions, permitting the use of alternative payment methods and will establish integrated databases that could support changes in benefit structure or administrative requirements.

The MTS will operate in a totally automated environment. Hospitals and other providers will transmit electronic claims directly to an MTS operating site. Claims inputs and outputs will adhere to standard formats as agreed to by the health care industry in cooperation with the American National Standards Institute.

One of the biggest problems faced by Medicare providers and beneficiaries is the paperwork they must deal with in situations where more than one insurance company or government program is liable for the payment of medical services. The Medicare transaction system will alleviate the problem through the promotion of automated exchanges of claims information between Medicare and other payers.

With MTS in place, intermediaries and carriers will continue to be the first level of contact for Medicare beneficiaries and providers. MTS will permit improved control over benefit expenditures. The system will provide for improved data and processing consistency.

MTS will provide Medicare with a greater capacity to profile services by provider and type of service and identify fraud and abuse in the course of processing claims.

Finally, the MTS will incorporate a greater capacity to provide the medical community and the public more comparative data on treatment patterns.

We have already begun a dialogue with beneficiary and provider groups from the MTS. Working closely with these groups as we develop and implement the system will ensure that expectations are met and that problems are quickly resolved. The Medicare transaction system will move us toward a future where Medicare responds more quickly, efficiently and economically in its administration of the program.

We look forward to working with the Congress and other groups in the public and private sectors to improve the systems that serve our beneficiaries. I would be pleased to answer any questions the committee has.

[The prepared statement follows:]

STATEMENT OF CAROL J. WALTON
MAY 25, 1993

Mr. Chairman and members of the Subcommittee, I am pleased to be here today to discuss the Medicare transaction system (MTS) initiative and the role it will play in administrative simplification.

INTRODUCTION

The skyrocketing costs of health care in the United States are reflected in the growth of the number of claims submitted to the Medicare Program. In fiscal year 1992, HCFA's 80 Medicare contractors processed almost 650 million claims at more than 60 separate sites across the nation. By fiscal year 1997, that number will grow to over one billion claims.

While Medicare's administrative expenditures compare very favorably with all other third party health insurance administrative costs, we believe the contractor budget will continue to be challenged in future years by the same constraints of limited funding and increasing workload faced by many other federal programs.

We have seen an increase in the complexity of the insurance/reimbursement process, causing what many have dubbed the 'hassle factor' for patients and providers. Only by employing new information systems technology will HCFA be able to continue to fulfill its claims payment responsibilities and reduce the "hassle factor". These new technologies can not only reduce processing costs but are an integral part of our efforts to reduce the complexity of Medicare administrative processes.

We have developed a strategy that addresses these issues and positions Medicare to respond to whatever challenges we may face following the conclusion of the national debate on health care reform.

The strategy has two key elements. The first is our initiative to replace the current 15 claims processing systems with a single, state-of-the-art Medicare transaction system. The second element calls for HCFA, working in partnership with other public and private insurers, to encourage medical providers to automate their billing and utilize information technology to reduce the administrative costs of health care.

EVOLUTION OF THE MEDICARE TRANSACTION SYSTEM

One of HCFA's basic missions is to ensure that Medicare claims are processed in a timely, accurate and cost-efficient manner. In the past, HCFA has contained the program's administrative costs, in the face of increasing workloads, through increased automation of contractor systems and encouraging providers to file electronic claims. Emphasis was placed on maintaining service levels to beneficiaries and providers while controlling overall contractor costs, especially overhead costs.

SHARED SYSTEMS AND COMMON WORKING FILE INITIATIVES

In the 1980s, the lack of uniformity in contractor operations, the high cost of implementing changes in numerous processing systems, and advances in electronic technology led HCFA to initiate a more organized approach to systems development. This approach led to what we call the Shared System and the Common Working File (CWF) Initiatives.

The initial step was to reduce the number of claims processing systems used by contractors through a shared systems policy. By pressing our contractors to share processing systems, we have gained the following benefits for the Medicare program:

- reduced duplication of effort in the systems area;
- reduced overhead costs; and

- reduced variation in processing.

The current systems fall into two types of shared systems models - shared maintenance or shared processing. Shared maintenance is an arrangement in which two or more contractors - called a user group - use the same claims processing system operated at their own individual computer facilities. However, all system software maintenance and enhancement activities are performed by a single maintenance contractor.

Shared processing is an arrangement in which several contractors use a single data processing center to process Medicare claims, with one contractor maintaining and operating the claims processing system.

In 1990, we proceeded with national implementation of the Common Working File (CWF) which is HCFA's first use of a single, national standard software system. Under the CWF, Medicare claims are processed by carriers and intermediaries, and then data are transmitted to nine CWF host sites to be integrated into a National Claims History file. The CWF serves as a check to ensure that Medicare's basic eligibility requirements, as well as other requirements, are met. All Medicare claims are now processed through the CWF before payment is made.

Despite the successful implementation of these initiatives, the Medicare claims processing environment remains fragmented at more than 60 Intermediary and Carrier claims processing sites. This fragmentation leads to inconsistencies in claims processing, extended implementation times for upgrades and enhancements, and duplication and redundancy for many operational steps.

ALL ELECTRONIC ENVIRONMENT

Over the past two years, HCFA has aggressively pursued the transformation of Medicare billing to an all-electronic environment. We have taken a leadership role in the health care industry in designing and adopting industry-wide standards for electronic data interchange.

Medicare was already the industry leader when we began our electronic billing initiative, and we have been extremely successful in encouraging providers to switch to electronic billing. Our intermediaries currently receive 87 percent of their claims electronically, up from 75 percent in 1991. Our carriers have also experienced a dramatic increase in electronic billing, from 35 percent in 1991 to 60 percent currently.

We believe that standardization of health care transactions among all providers and payers would be a major step toward administrative simplification. We are active participants in the American National Standard Institute's (ANSI) effort to develop new electronic data interchange standards and, in October 1992, were the first payer to implement the first approved ANSI health care standard, the electronic remittance notice.

We are also active participants in the Workgroup on Electronic Data Interchange or WEDI. WEDI is attempting to develop industry plans for adopting ANSI standards; common patient, provider and payer identification numbers; coordination of benefits; telecommunications standards; and other key industry standards.

THE MEDICARE TRANSACTION SYSTEM (MTS)

Last September, HCFA announced an initiative to meet the claims processing challenges that will confront Medicare over the next two decades -- the Medicare transaction system (MTS). The MTS will be a single, consolidated claims processing system replacing the 15 claims processing systems now being used with a single

uniform system at an optimal number of sites across the country. The MTS initiative will capitalize on the trend toward an all-electronic environment.

MTS will be managed by the Federal government but will be developed, maintained, and operated by private contractors. Implementation will begin in 1996. We project that the design, development, and implementation costs will be fully recovered by 1998.

Through economies of scale, MTS will lower the overall cost of claims processing while improving service to both beneficiaries and providers. The costs of maintaining, enhancing, and implementing changes to the claims processing system will be significantly reduced because changes will have to be programmed only once, rather than many times at many separate sites.

The design will be able to support a variety of transactions, permitting the use of alternative payment methods, and will establish integrated data bases that could support changes in benefit structure or administrative requirements.

By the end of 1993, HCFA expects to award a contract to an outside organization to design and develop the Medicare Transaction System.

HOW MTS WILL WORK

The MTS will operate in a totally automated environment. Generally, hospitals and other providers will transmit their electronic claims directly to an MTS operating site. Claims inputs and outputs will adhere to standard formats as agreed to by the health care industry in cooperation with the American National Standards Institute.

One of the biggest problems faced by Medicare providers and beneficiaries is the paperwork they must deal with in situations in which more than one insurance company or government program is liable for the payment of medical services. MTS will alleviate this problem on several levels through:

- The ability to check eligibility information, including other payer information through the inquiry system, which will greatly assist in determining the payer of record;
- More uniform application of payment rules, which will allow providers to predict more accurately how much they will be paid for services;
- An increase in the consistency and accuracy of claims determinations; and
- The promotion of automated exchanges of claims information between Medicare and other payers.

Intermediaries and carriers are sometimes hampered in their ability to serve providers and beneficiaries because they lack timely access to necessary information. MTS will improve beneficiary services on several fronts. MTS will establish a nationally coordinated claims "suspense" system that will provide complete and accurate information on claims status. By providing access (consistent with privacy constraints) to a beneficiary's claims history and pending file, MTS will provide HCFA contractors with better data to explain Medicare benefits and to explain a decision on claims. By integrating both Medicare Part A and Part B claims into a single system, a beneficiary provider will be able to determine the status of claims for an episode of illness with only one phone call.

Even with MTS in place, intermediaries and carriers will continue to be the first level of contact for Medicare beneficiaries and providers. Relief from the performance of

automated claims processing functions will enable intermediaries and carriers to focus their resources on providing quality services to their Medicare customers.

MTS will also permit improved control over benefit expenditures. The system will provide for improved data and processing consistency and greater assurance of the appropriateness and accuracy of program benefit payments.

Because of the integration and consolidation of all claims processing under MTS, HCFA's electronic claims analysis capability will improve significantly. MTS will provide greater capacity to profile services by provider and type of service, as well as the potential to identify fraud and abuse in the course of processing claims. Thus, MTS will improve both the effectiveness and efficiency of HCFA's medical review and fraud and abuse functions.

Finally, the MTS will incorporate a greater capacity to provide the provider and the public with more comparative data on treatment patterns. Because the MTS will be a national, standard integrated system which will maintain the only complete beneficiary and provider claims history files, it will provide summary reports to support various post-payment review activities, including reviewing utilization patterns, performing medical review, and investigating fraud and abuse.

MTS OUTREACH

We have already begun a dialogue with beneficiary and provider groups on the MTS. Earlier this year, we met with many beneficiary and provider groups on the MTS background and strategic goals. Discussions with representatives of the hospital and health care community included the American Hospital Association, the American Medical Association, the Healthcare Financial Management Association, the Association of American Medical Colleges and the National Association of Rehabilitation Facilities. HCFA intends to conduct regular consultations with beneficiary and provider groups to enhance the system capacity to meet beneficiary and provider needs. We also plan to consult with beneficiary and provider groups in developing our transition plans. HCFA is committed to a smooth and trouble-free transition from the current environment to the MTS. Working closely with our customers will ensure that expectations are met and that problems are resolved quickly.

CONCLUSION

We look forward to a future when Medicare responds more quickly, efficiently and economically to challenges that may come its way. The Medicare transaction system promises to provide that future through administrative simplification of the Medicare program. And, we look forward to working with the Congress and other groups in the public and private sectors to improve the systems that best serve our program beneficiaries.

Chairman STARK. Ms. Walton, as far as you know, what type of a number will be used? The Medicare number for beneficiaries, will that be the unique number that will identify the beneficiaries in your system?

Ms. WALTON. Currently, the number that HCFA uses, the HI claim number is a very close relative of the Social Security number.

We are hoping to see national standards developed for all the numbering systems, not only for——

Chairman STARK. I don't care about what other people are doing.

As far as you know, is HCFA planning to go to the Social Security number or not or is that undecided?

Ms. WALTON. It is undecided at this time.

Chairman STARK. What steps are you aware of to integrate this uniform system with other Federal systems, IRS, for example, Social Security, Defense Department personnel? Have any steps been made to see that this information is readily interchangeable with other Federal programs?

Ms. WALTON. We are in conversation with other Federal insurance programs like CHAMPUS for——

Chairman STARK. Other Federal agencies.

Let's start with the Social Security agency. Is there any steps being made to make sure that this information and the protocols involved in this new system will allow interchange of information between Social Security and HCFA, for example?

Ms. WALTON. To the best of my knowledge, the only data exchange that happens between Social Security and Medicare is when we are having difficulty identifying situations where Medicare is the primary payer.

Chairman STARK. I understand that. I am just asking have any steps been made in HCFA to see that these two systems will be able to integrate data should we need to do that?

Ms. WALTON. Obviously, the basic numbering system is consistent with the Social Security Administration, our data——

Chairman STARK. We have heard that we have piles of records that we can't compare with other records in other departments because the formats are different or the protocol is wrong.

I would urge you—to start with the Social Security Administration, which is under the direction of the Secretary, to see that at least departments within Health and Human Services can share this data. Medicaid and Medicare, for example—will Medicaid data be readily transferable and shareable with Medicare data?

Ms. WALTON. Absolutely with Medicaid. I understand what you are saying for other Federal agencies, and we will be sure to coordinate with them.

Chairman STARK. Now let's go next to the Internal Revenue system. It would be a good idea, if you haven't, to make absolutely sure that that data can be shared, interchanged, sorted for most interesting reasons. Does that make good sense?

Ms. WALTON. I understand. We will definitely expand our scope of discussion beyond Medicaid. And I understand your point. It is an excellent point.

Chairman STARK. The Veterans Administration. If we do it in the beginning, even though we are not sure we will be able to use it—it would be terribly frustrating to spend all this time and money

and suddenly to find, oh, oh, we have a different system and everybody else has PCs and we have a Mac or whatever the system or problem may be.

So I would urge on you, one, that you get us close to the Social Security number, that you use it and then find ways to keep the privacy; and, secondly, that we make sure that the other agencies are aware of this. I would say that is more important than being greatly concerned with what the private insurance companies are doing. They will follow, and somebody has to set the standard.

I am not sure one is better than the other, but I am sure that if everybody has a different protocol the system is no good at all, and if we all wait to decide among 15 or 16 intermediaries who has the best system, you and I will be long gone and retired by the time they agree as to what is the best system.

You pay a third of the bills. Why don't you just set the system? And it will be the best. How is that?

Ms. WALTON. Sounds good to me.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

My understanding is that this MTS process is moving along reasonably well in the hospital area. It is also my understanding that, in that area, the various insurers are still going to have their individual section of the bill. I wonder how much simplification are we really going to get in the hospital area?

Ms. WALTON. In the past, standardized claim forms have allowed different insurance companies to have specialized areas where they are different. I think that is what we have seen with the hospital billing form, the UB–82, and I think that is the same situation we have seen on the ambulatory bill, the 1500.

I think that if we really want to take advantage of administrative simplification savings and take a lot of hassles out of the system for the providers, then we will truly have to look very hard at making everything uniform, the data format.

Mrs. JOHNSON. I agree with you absolutely, but my question is what kind of progress are we making?

Ms. WALTON. Well, the WEDI group, this work group for electronic data interchange which involves the entire insurance industry coming to the table and saying, "yes, I think we do need to standardize," is making enormous progress.

I think a few years ago other insurance companies would not have been able to agree on standards. I think even Medicare has said, well, the law is the law is the law. I have to do what I have to do when I have to do it. And now we are trying to work together to come up with standards. So I think just making that recognition is a giant step.

I think what is important for me and I think also for you in assisting us is to make sure that we don't lose momentum. And if we need some extra pushes, I hope Congress will push us along. I think it is very important for the Nation.

Mrs. JOHNSON. I do agree that working together is the only way to really solve this, that we have to get the technical problems ironed out before we get into it rather than after, but I am concerned that we come out with quite a lot more simplification than now.

My followup comment is simply that, in regard to office practice simplification, I am getting from the local level the input that this group process is so light on participation by those who manage benefit payment at the physician office level that they feel they are not being heard. And they feel the process that goes on amongst insurers and the government to talk about billing simplification is not a process that understands the problems that the individual physician faces with all of these payers, nor the system's capability of the individual office to respond. So I just want to alert you to that.

I think there are far bigger problems there than we are realizing. And since that is a lot of the hassle and cost problem, I would like to help in any way I can to rebalance the process because there are some very good heads out there that are very committed to what we want to do, but the structure of the groups is not in my mind sufficiently balanced at this time.

Thank you.

Ms. WALTON. Thank you.

Chairman STARK. Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman.

Ms. Walton, we heard from CBO about the additional costs of incorporating into any system copays and deductibles. It is my view that any health care reform bill that we address will have that component or those components in it. Now, in your knowledge of the MTS that you are trying to develop, how is that handled and how are you going to try to provide some economies when it comes to yet an additional billing for copays and deductibles?

Ms. WALTON. Since Medicare has copays and deductibles and something unique called a spell of illness, I could certainly attest that there are complications that add costs to the system. The best way to minimize these kinds of costs is through a highly automated system that gets all of the beneficiary's bills in one place very quickly, hopefully as soon as the bill is filed so that you don't have rework or error in the system by mistakenly paying when they haven't met a deductible, et cetera.

So, for example, what we envision in our Medicare transaction system is an on-line inquiry that would allow the provider to see if the deductible had been met so they would get it right the first time. That is the way we keep our costs the lowest.

Mr. KLECZKA. On copays, a similar type of a system?

Ms. WALTON. The copays are a little more straightforward because it is a straight percentage that the patient always owes, so it is a little bit easier to handle.

Mr. KLECZKA. OK. Thank you very much.

Chairman STARK. Thank you, Ms. Walton. We appreciate your contribution. We will be here to kind of push you along to see that you can get this project completed. It is something that the Chair has been interested in for many years, and I am sure now that we have some broad bipartisan interest we can maybe even speed the program up.

I am a little concerned that we are going to wait as long as we have to, and maybe we will just push the urgency button on this project and get it speeded up. I think we would all benefit from it.

Thank you very much for participating today.

Ms. WALTON. Thank you.

Chairman STARK. Our next witnesses will comprise a panel: The American Hospital Association, represented by David Bernd, the chief operating officer of Sentara Health Systems in Norfolk, Va.; the American Medical Association, represented by Dr. John Clowe, who is accompanied by David Heidorn; the Blue Cross and Blue Shield Association, represented by Alissa Fox, accompanied by Jim Christie; and the Health Insurance Association of America, represented by Edward Neuschler.

Mr. Bernd, you are first on the list. Why don't you lead off?

STATEMENT OF DAVID BERND, EXECUTIVE VICE PRESIDENT AND CHIEF OPERATING OFFICER, SENTARA HEALTH SYSTEMS, NORFOLK, VA. ON BEHALF OF AMERICAN HOSPITAL ASSOCIATION

Mr. BERND. Thank you, Mr. Chairman.

My name is David Bernd, and I am pleased to be here to present testimony for the American Hospital Association on the issue of simplifying health care administrative cost processes.

The need for simplification is something on which hospitals, physicians, insurers, consumers and government can all agree, because the burdens of processing and producing clinical and payment information are growing. We must simplify the system, eliminate unnecessary costs and standardize the data content as well as the processing and transmission of this data.

This standardization must be achieved before we can move to fully automating these processes. Moreover, there are additional steps that must be taken to smooth the way for these changes, including changing State laws that require paper records and that do not recognize electronic documents as official.

Key among these changes, we believe, is the creation of national standards to continue to protect the confidentiality of patient records in a new electronic environment. Ultimately, our ability to achieve truly efficient administrative systems will depend on how we reform our current health care delivery and financing systems.

Mr. Chairman, I would like to take this opportunity to tell you a little bit about Sentara Health Systems and how we are preparing for the future. Sentara Health Systems is a nonprofit organization located in Norfolk, Virginia. It is an integrated health care organization, both vertically and horizontally, made up of 4 hospitals, 10 nursing homes and 3 HMOs. The three HMOs that are owned by Sentara are a staff model HMO, an IPA HMO, and the only Medicare HMO in the State of Virginia.

Sentara is in Norfolk, Virginia, which is 1 of the 50 largest metropolitan areas in the United States. It is one of the handful that does not have a governmentally run hospital so that the private institutions must take care of all the indigents in our community. We provide over $40 million a year in indigent care and major teaching expenses to the Eastern Virginia Medical School as a private institution.

I would also like to share with you some of the many inconsistent and costly administrative rules that hospitals must follow to get claims processed and paid. These are by no means intended to be inclusive but represent some of the more onerous situations.

First, the split billing requirements. In Virginia, Medicaid requires inpatient services that span the hospital's fiscal year to be split so two bills will be produced. Blue Cross in our State requires some claims to be split by calendar year while other claims under other contracts do not require splitting. Commercial carriers may require calendar year splits or splits based upon their plan's benefit year.

Conflicting definitions of inpatient versus outpatient services is also a problem for our industry. Federal payers and private insurance industry have differing definitions of outpatient and inpatient services.

For example, Medicare and CHAMPUS have defined services as observation, that is outpatients that were traditionally inpatients. The Medicaid program, however, does not recognize observation as a type of service and requires the same treatment to be billed as inpatient.

Commercial carriers, HMOs and Blue Cross all have their own rules regarding the definition and billing of these services. As a consequence, hospitals must manually review all potential cases to insure the multiple, unique payer criteria are satisfied. This is an expensive, costly procedure since it often requires someone with clinical expertise.

An additional integral part of this process is the continuing education that must be undertaken to educate the office staffs of our private practice physicians on these varying rules and documentation requirements.

The Medicaid program in Virginia has narrowly defined what is a valid medical reason to be in an emergency room to be seen by a physician. This is done by eliminating reimbursement based on the ICD–9 code diagnostic codes within a certain range. Diagnoses falling outside this range are reimbursed at an office visit rate of around $30. The cost of copying, handling, mailing these bills is high and on some cases averages $22 based on management and engineering studies done within our organization. This cost is in addition to the cost of providing the medical services.

The last thing I would like to talk to you about is the reengineering effort we're undertaking at Sentara in the area of patient billing. As a direct result of the many different and in some cases conflicting payer requirements, hospitals have billing processes that are labor intensive and costly. A continuous quality improvement team reviewing our internal processes identified a potential of 108 steps from the time a patient is first identified to the end of the billing collection cycle. Not all payers require us to go through the 108 steps. That is the worst case example.

We have provided to the committee members a copy of the flow chart from the continuous quality improvement team that actually outlined 70 of these 108 processes. If you would like copies of that, we have them available. While not every account requires all of these steps, as I said, many of them do.

The team working on this project determined that if consistency and full automation capabilities could be realized a reduction of almost 40 percent of the staff in the patient accounting department could occur. This reduction alone would yield $1 million a year in direct savings to our patients.

Sentara is involved in major reengineering processes. In 1992, we received the National Quality Award from RIT USA Today with over 400 CQI teams which were put in competition for this quality cup.

In conclusion, Mr. Chairman, AHA applauds your efforts in the area of administrative cost simplification and particularly your responsiveness to our concerns voiced last year. We thank you for the changes you included in H.R. 200.

We believe we can achieve real benefits and cost savings by standardizing the collection, use and transmission of data, eliminating barriers to more efficient administrative processes and encouraging the development of local data networks. These reforms can mean lower health care costs as well as less frustration for our health care administrative system.

Thank you.

Chairman STARK. Thank you.

[The prepared statement and attachments follow:]

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Statement
of the
American Hospital Association
before the
Subcommittee on Health
of the
Committee on Ways and Means
of the
United States House of Representatives
on
Administrative Simplification in Health Care

May 25, 1993

SUMMARY

- **Diverse payer demand for data, and new and complex payer review processes, have increased administrative costs dramatically and constitute a mass of paperwork and information demands that burden providers, payers, and patients alike.**

- **Addressing provider concerns about excessive administrative costs will require elimination of unnecessary administrative functions that differ across payers, and not simply the automation of existing information systems.**

- **Aligning information needs/demands across payers will require a number of fundamental reforms, including: standardization of data content; standardization of information processing and review procedures; standardization of transmission formats and protocols; elimination of barriers to efficient processing; and development of shared information networks.**

- **Ultimately, our ability to achieve truly efficient administrative systems will depend on how we reform our current health care delivery and financing systems.**

- **Administrative simplification reforms that we adopt now must not lose sight of how future delivery and payment systems will be structured and must recognize the local nature of the delivery of health care services both now and in the future.**

Mr. Chairman, I am David Bernd, Executive Vice President and Chief Operating Officer of Sentara Health Systems in Norfolk, Virginia. On behalf of the American Hospital Association's (AHA's) more than 5,000 member hospitals, I am pleased to testify on the issues that need to be addressed and the steps that need to be taken to simplify health benefit administration.

Over the years payer demand for data from health care providers and new and more diverse and complex payer review processes have increased administrative costs dramatically. Information demands are open-ended and often contradictory. These diverse information demands for medical review activities and the billing, processing, and payment of claims

constitute a mass of paperwork that burdens providers, payers and patients alike, and creates a barrier to fully electronic communication.

AHA supports the subcommittee's efforts to simplify health care billing, claims processing, and payment systems to eliminate wasteful administrative systems and, thereby, help reduce our nation's escalating health care costs. Hospitals support these reforms. In fact, there is general agreement among providers, payers, and policymakers that we can take significant steps to improve the efficiency of the administrative systems that support our health care system.

Improving efficiency means addressing the administrative costs of both providers and payers. Simply computerizing our current systems does not accomplish this. We must take a careful look at both the structure and purpose of our administrative systems to see how we can streamline not just the transmission of information but what we collect, how we collect it, and how it is used. In other words, administrative simplification will mean more uniformity and consistency in our administrative system and not just better technology for managing our current burdensome and confusing administrative systems.

Addressing provider concerns will require elimination of unnecessary administrative functions that differ across payers. We must trim away the layers of administrative flab that clog the current environment with redundancy and specialized reporting. We must focus on standardizing both the content and the processing of information--i.e., aligning information demands across payers.

We believe providers and payers can collaborate to bring about needed reforms. There are currently a number of efforts underway in the private sector focused on administrative simplification. Some of the goals defined by these efforts include:

- Full implementation by January, 1994 of an improved uniform billing document that should eliminate the need for attachments.
- Development of national standards for a uniform clinical data set within the next three to four years.
- Implementation of standard electronic formats across all providers and payers by late 1996.

The success of these efforts depend on all involved parties agreeing to reduce administrative costs and not passing these costs on to others. Success also depends on having the right incentives in place and eliminating current state and federal statutory barriers to reaching these goals. Along these lines, legislation, such as a federal law on the confidentiality of patient records within an electronic environment, will need to be enacted.

Ultimately, however, simplifying current systems will not be enough to eliminate unnecessary administrative costs. We must overhaul the way we deliver and pay for health care if we are to effectively streamline our administrative systems. Changes such as a mandated national basic benefit package and capitated payment for that package would go a long way toward simplifying the administrative systems needed to support the delivery of health care services in this country. National requirements for public reporting on the cost, quality, and utilization of services under health care reform would further facilitate uniformity and consistency.

Thus, while we can take significant steps today to simplify our current administrative systems and contain administrative costs, we must not lose sight of how administrative systems need to be redesigned to support and accommodate long-term health care reform.

To begin, we must address fundamental deficiencies of the current environment. A series of key reforms are necessary:

- Standardization of data content;
- Standardization of information processing and review procedures;
- Standardization of electronic transmission formats and protocols;
- Elimination of barriers to efficient processing; and

- Development of shared information networks

Each of these steps will contribute to the simplification of our current administrative systems and form a foundation for administrative systems needed to support future reforms to our health care delivery and payment system.

Standardization of Data Content

Standardizing data content is not just a matter of identifying which data elements should be collected. It also means agreeing on the definition and codes for those data elements. Currently, when payers appear to be asking for the same data elements, they could be asking, in fact, for very different information. For example, to identify a physician, some payers want the Medicare physician number, while others may want the physician's state licensure number or federal tax identification number. Payer requirements for the collection of other data elements can be equally diverse and confusing, such as different rules for diagnosis and procedure coding or different methods for determining entitlement information. These differences add up to enormous costs for providers. We appreciate the fact, Mr. Chairman, that you have addressed this problem in H.R. 200. AHA and other provider and payer groups continue to work successfully on a voluntary basis to increase the uniformity in payer data requirements.

With regard to billing, progress has been made over the past 20 years through the National Uniform Billing Committee (NUBC) for institutional claims, and the Uniform Claim Form Task Force (UCFTF) for professional claims, to move toward payer acceptance of uniform billing data sets and formats. These committees, broadly representative of payers and providers, work on an ongoing basis to establish and maintain common data sets that can be used universally by payers, thereby eliminating or at least reducing the need for specialized data requests.

The NUBC, working with State Uniform Billing Committees (the state equivalents to the NUBC), has revised the old institutional uniform bill, the "UB-82", into the "UB-92" which will be implemented beginning on October 1, 1993. In revising the uniform bill, efforts have been made to eliminate the need for additional information. While most payers (in particular two of the largest payers, Medicare and Blue Cross Plans) accept the uniform bill without additional attachments or itemization, other payers, most often commercial insurers, require additional information that is often redundant or unnecessary for the actual processing of claims.

The NUBC and UCFTF already provide private sector mechanisms for establishing and maintaining uniform data sets for billing health care services, and these efforts should be built upon in any effort to standardize billing data content. We could realize immediate savings if all insurers would agree to limit themselves to these data sets, as Medicare does, for adjudicating claims. Unfortunately, this is not currently the case. For this reason, legislation mandating uniform institutional and professional bills, ultimately, may be necessary. If such legislation is passed, we would recommend that the NUBC and the UCFTF be identified as the bodies to maintain the uniform bills as they do in their current capacity.

With regard to medical review, more clinical detail is needed than is currently captured through the claims system. Payers are increasingly hungry for patient-level clinical data not only to adjudicate claims, but to support broader evaluations of health care cost and quality, provider efficiency, and treatment effectiveness. Although providers recognize the importance of evaluating the cost and quality of care, the nature and extent of data demands can be very time-consuming and costly and may divert resources from patient care activities. External organizations frequently do not evaluate their data demands to determine whether all of the information they are requesting is necessary, reliable or valid for their intended purpose. Moreover, there has been virtually no effort on the part of these organizations to coordinate requests or identify core sets of data that could serve multiple purposes.

Once all clinical information is computer-based, the transmission of detailed clinical information for use by regulators, evaluators, purchasers, and researchers will be relatively simple. In early 1992, the AHA convened a Work Group on Computerization of Patient Records, consisting of representatives of providers, payers, government, consumers, and business, to identify practical steps to support the devleopment and implementation of computer-based patient records (CPRs). The Executive Summary of the work group's report, *Toward a National Health Information Infrastructure,* is attached to this statement. That report suggests that it will be 15 or more years before all providers have fully operational CPRs. Until we have widespread implementation and use of CPRs, the only way to build data bases of detailed clinical information is to collect information from existing paper records and enter it into a usable electronic format--a labor intensive and costly enterprise.

Perhaps the most significant example of such a system is the Uniform Clinical Data Set (UCDS), which was developed by the Health Care Financing Administration to collect information needed by the Medicare Peer Review Organizations (PROs) to evaluate the quality and appropriateness of care provided to Medicare beneficiaries. Data abstraction to support UCDS could be in excess of $500 million dollars. Yet this comprehensive data set has never been evaluated to determine whether the data are necessary or sufficient to streamline the medical review process. At the present time, there is no general agreement among experts on what a minimum clinical data set should contain. There must be a mechanism for balancing the usefulness of information with the cost of data collection before such a data set could be broadly implemented.

Thus, before a uniform clinical data set, comparable to the uniform billing data sets, can be established, there needs to be substantially more study and evaluation. We would support such efforts, in particular those of the Agency for Health Care Policy Research (AHCPR), which is currently acting as a coordinator for planning panels that are looking at ways to integrate the collection of clinical information. Once this research is done, we could support a mandate for a clinical data set as long as it was limited to the minimum amount of data required for medical review and as long as there was balanced representation on the body identified to maintain this data set.

Standardization of Information Processing and Review Procedures

In addition to standardizing data content, further administrative cost savings could be achieved by standardizing methods to access and process information as well as review procedures for analyzing the information.

For example, with regard to billing and claims processing, centralized enrollment and coverage determination could go a long way toward reducing provider administrative costs. This could be accomplished through the use of beneficiary or enrollee health claims cards or similar methods that permit immediate electronic verification of eligibility and benefits. Again, Mr. Chairman, this is an issue that we are pleased that you have addressed in H.R. 200.

With regard to medical review, there is even greater need to establish more uniform review procedures. Currently, much of the external review is done on a case-by-case basis, with enormous variation in data demands and administrative processes that can consume the time of physicians and hospital staff that would be better spent on patient care. National standards for these procedures would help reduce some of the friction that now exists between external and internal utilization management programs.

In the long run, however, the administrative costs associated with medical review can best be minimized by developing methods to move away from the intensive case-by-case scrutiny of individual claims. By enhancing the ability of external evaluators to assess overall provider performance, reviewers will be able to target utilization management on diagnoses, providers, or geographic areas where utilization or quality appear out of line with norms. Techniques for performing these sorts of evaluations exist, but purchasers are hampered by

the lack of adequate data. In early 1992, the AHA convened a Work Group on Performance Monitoring, consisting of providers, insurers, consumers,and employers to evaluate the adequacy of data currently collected for performance monitoring and seek ways to satisfy the need for more complete and consistent information about patients that could be used for this sort of performance monitoring. The report of that work group is expected later this year.

Standardization of Electronic Transmission Formats and Protocols

Currently, there are over 400 different proprietary electronic format designs to carry billing information. Without standardization of electronic processes we could see further fragmentation and higher administrative costs as competition among these firms increases.

The American National Standards Institute (ANSI) has already made some significant progress in designing the standardized electronic formats for the transmission of health care data. In addition, the Workgroup on Electronic Data Interchange (WEDI), an ad-hoc group of payer and provider organizations formed in late 1991, has been working diligently toward the general acceptance and use of these electronic standards. WEDI issued its first report in July 1992, and has been working on a follow-up report for release this summer.

Guidelines on the use of electronic format standards, however, must avoid allowing proprietary interests from controlling and dictating transmission processes and costs. New relationships must be nurtured that level the field so that rules on how information standards will be enveloped in an electronic format do not permit proprietary interests to dictate the processing environment.

To assure that the standard electronic formats are used correctly, committees like the NUBC and the UCFTF for billing, and any other appropriate group for clinical information, should assume the role of defining how uniform billing and clinical data sets will be enveloped into the ANSI electronic format. The NUBC and the UCFTF, in fact, are already in the process of developing implementation guides to the ANSI standards.

Elimination of Barriers to Efficient Processing

A number of existing laws and regulations present barriers to the development of efficient information processes. For instance, some state laws do not recognize information that is maintained as a document in electronic media as being "official". Consequently, much of the information maintained in electronic form must also exist in paper form.

Some states effectively prohibit the use of computerized patient records by requiring that orders and/or practitioner's signature be written in ink. These laws and other such laws requiring paper records were passed before the age of electronic record storage. While they have served a useful purpose, they must now be modified to accommodate electronic systems. Another barrier is the patchwork of state laws governing confidentiality of the patient's health record. The diversity of these state requirements inhibit the use of electronic media.

Still other barriers include the different rules and regulations for determining primary, secondary, or tertiary payer. There needs to be a process that establishes uniform rules to follow throughout the country on coordination of benefits. Many different state laws require different protocols when multiple benefit plans or liability carriers are involved.

Establishing Shared Information Networks

The delivery of health care services is a local issue, and is likely to continue to be so even under national health care reform. This means that the information networks that are established to support both our current and future health care information needs must be locally based. At the same time, there will be a critical need to share information in order

to improve the overall management and efficiency of our health care system and to monitor the effectiveness of the care our system delivers.

Achieving the goal of shared information networks will require that the roles and responsibilities of all participants--providers and payers--be clearly defined. Each participant must understand its role in developing, maintaining, and using information. Consequently, the relationships between individual participants becomes more significant as databases develop, storage requirements evolve, and processes for access become defined. There needs to be a lot of experimentation in establishing locally integrated information systems before we know best how to form a national data network.

Experimentation with community health information networks is just beginning. These sorts of demonstrations could prove invaluable to the long-term development of computer-based patient records, and may also offer opportunities for improving the quality and efficiency of clinical information transfer in the near term. Although as yet there are no operational examples of community health information networks, a few communities are planning networks that will link health care providers so that patient health information can be shared across time and place. These demonstrations deserve to be supported.

However, the more patient information is shared among caregivers, payers, and others, the greater the threat to patient privacy. The potential for large-scale breaches of confidentiality is magnified by the ease of sharing documents in a computer environment. Current patient privacy laws vary significantly from state to state, often conflict, and seldom consider the implications of electronic records. This patchwork of laws governing confidentiality of patient records may inhibit providers from sharing information outside their organization electronically, and, worse, may induce patients to withhold information essential to their care. We believe national standards need to exist for protecting the confidentiality of patient information.

LONG-TERM REFORM AND FUTURE ADMINISTRATIVE SYSTEMS

Although we can achieve significant savings through efforts to simplify our current administrative systems, ultimately our ability to achieve truly efficient administrative systems will depend on how we reform our current health care delivery and financing systems. In particular it will depend on our ability to establish uniformity in the health care benefits available to everyone in this country and our ability to establish self-disciplined local delivery networks to deliver those benefits.

As you know, the AHA has a vision for the future of our health care system that is built around fundamental restructuring of our financing and delivery system. We envision the creation of community care networks^{SM}, integrated consortia of providers and payers and others formally organized at the local level to provide a common set of benefits to everyone through a pluralistic system of financing. Such a network would be paid on a capitation basis--a fixed amount per enrollee per year--for the entire range of specified benefits and would be required to be accountable to its community through, among other things, public reports on the cost, utilization and quality of the services it delivers. Administrative costs could be substantially reduced through the combined impact of standardized benefits--which would eliminate diverse coverage rules--and capitated payment for these benefits--which would reduce the magnitude of claims transactions.

Under the AHA vision, an independent national commission would oversee the reformed health care system. The commission would make important decisions about the health care system including establishing a uniform national benefits package, establishing qualification criteria and standards for community care networks, and setting capitated network payment rates for the government-financed program.

This commission also would likely have the authority for overseeing the development of standards for uniform data reporting requirements on the costs, utilization, and quality of

health care services. In developing these standards, as well as the implementation guides and instructions for communicating the uniform data, the commission could rely on committees, like the NUBC and the UCFTF, that are currently responsible for the development, maintenance, and transmission of uniform data sets.

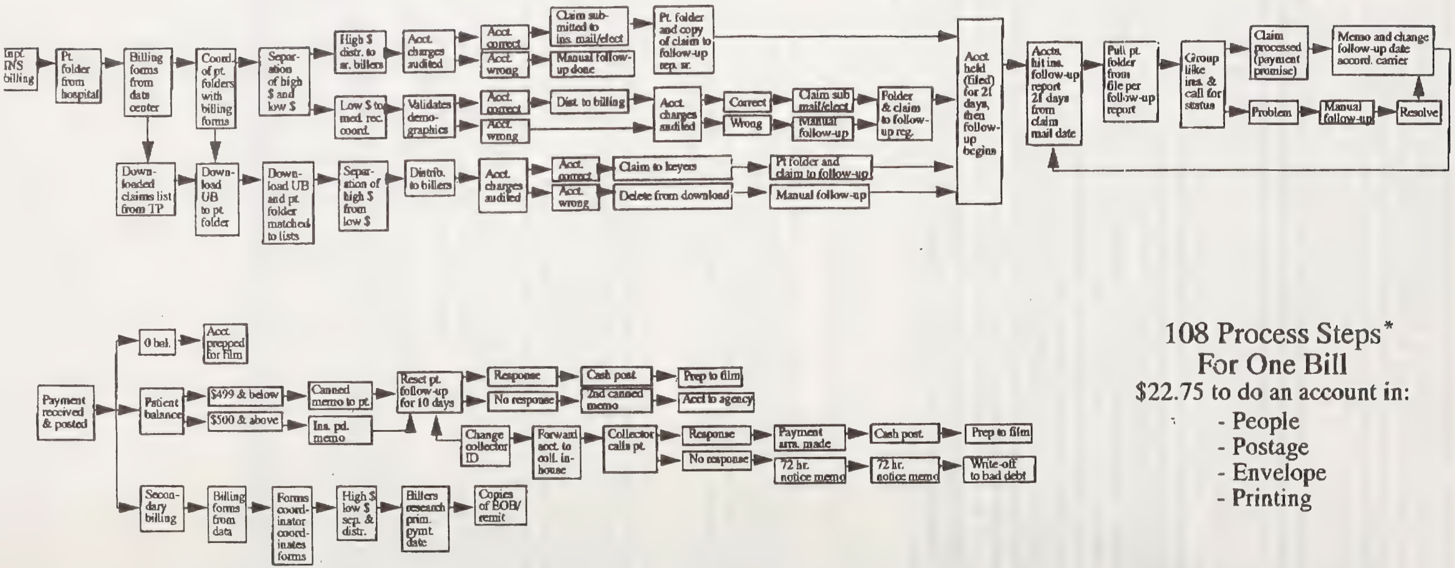
CONCLUSION

The reform or restructuring of our financing and delivery system will ultimately determine how our administrative systems are structured. Nevertheless, we can achieve real benefits and cost savings by standardizing the collection, use, and transmission of data, eliminating barriers to more efficient administrative processes, and encouraging the development of local data networks. These reforms will:

- Reduce the collection of redundant and unnecessary data;
- Increase operational efficiency for providers and payers;
- Reduce training costs for new staff;
- Improve coordination of claims information among primary, secondary, and tertiary payers;
- Increase efficiencies through the use of computer technologies;
- Enhance data availability for research;
- Reduce administrative "hassle" for consumers; and
- Provide greater information sharing among all participants (providers, patients, and consumer) in health care.

These benefits represent a win-win situation. They mean not only lower health care costs but less frustration with our health care administrative systems.

Patient Billing Process



108 Process Steps*
For One Bill
$22.75 to do an account in:

- People
- Postage
- Envelope
- Printing

SENTARA.
Health System

*(Over 70 illustrated on this chart)

EXECUTIVE SUMMARY

Background

In November 1991, the Secretary of Health and Human Services convened a forum of health care leaders to identify ways to reduce health care administrative costs. After the forum, the following working groups were created: the Work Group for Electronic Data Interchange, the Work Group on Administrative Costs and Benefits, the Work Group on Performance Monitoring, and the Work Group on Computerization of Patient Records. The latter work group, including organizations representing patients, providers, purchasers, evaluators and health policy experts, was assembled by the American Hospital Association to identify practical steps towards the implementation of computer-based patient records.

Current Environment

Today, patients' health information is often fragmented, poorly documented and duplicative. Information about a single episode of care could reside in the records of several different providers -- history and symptoms in a physician record, lab results and surgical procedures in a hospital record, and rehabilitation in a home care agency record. Even within a single provider location, such as a hospital, information about a patient may be contained in different departmental systems, some of which are computerized, some of which are not, and few of which are integrated due to the lack of standards for defining, coding and transmitting data.

Generally, providers have been unwilling to invest large sums of money in information systems without assurances that the costs will be justified by the benefits. Several advanced computerized patient record systems have been successfully installed in hospitals and ambulatory care settings but few have been widely replicated and information about the costs and benefits is limited. In particular, there is little scientific evidence to prove that CPR systems will reduce administrative costs. There are, however, several studies that show the CPRs can lead to better quality and more efficient patient care management (e.g., fewer lab tests, shorter lengths of stay).

Vision

This work group believes that we must harness the capabilities of computers to improve the quality and efficiency of patient care. More complete and accurate patient information will become available across time and place (with appropriate safeguards for patient privacy). Caregivers will have access to practice guidelines, prompts, reminders, and other decision support tools to enhance diagnosis and treatment and to evaluate the likely outcomes of alternative treatment options. Patients and purchasers will be able to obtain information on the cost and quality of health plans and providers. Researchers, regulators, health plans, evaluators, and policymakers will have access to data to support decisions about health care delivery and financing and evaluating the effectiveness of emerging health care technologies. Costs will be reduced by eliminating redundant functions and streamlining inefficient processes.

In order to achieve our vision, we need a **health information infrastructure** -- an interconnected communication network linking all participants in the U.S. health care system. Each health care facility and practitioner would connect to the network via its own **computer-based patient record system** -- an information system that would have the ability to create, store, retrieve, transmit, and manipulate patients' health data in ways that best support decision making about their care. In addition, support for better patient care decision making and analysis of patient outcomes would be available through **reference data bases** -- aggregate data from many patients -- and **computerized knowledge-based systems** which use decision logic and practice guidelines to help caregivers make decisions about diagnoses and treatment options. As they do today, health care providers would control access to information stored in patient records in order to preserve patient privacy. When authorized, data from such a system could flow to health care managers, policy makers, researchers, and purchasers to monitor the performance of the health care system and make key decisions for the future.

Strategies

We believe that with a well-planned, adequately financed, and incremental approach, this vision is attainable in the next ten to fifteen years. The strategies we propose represent first steps in the development, adoption and use of CPR systems and the health information infrastructure.

- **Develop national standards for documenting and sharing patient information**. The American National Standards Institute Healthcare Information Standards Planning Panel (HISPP) should coordinate the development, adoption, and use of national information standards. Standards should be developed for patient data definitions, codes and terminology, for inter-system communication, and for uniform patient, provider, and payer identifiers.

- **Establish national standards for protecting the confidentiality of patient information.** Enact federal legislation applying to all health information which resolves inconsistencies and inadequacies in existing laws protecting patient privacy and creates a Federal Information Privacy Commission to establish uniform requirements for protecting health information.

- **Improve knowledge about the state-of-the-art**. Better information should be collected and made available about what kind of information systems providers have, how much systems cost, how much they save, how they could be used more effectively, and how they could be improved.

- **Promote development of interconnected communication networks.** Federal funding should be provided to support the development of health information networks that operate to share health information between providers and others within a community. Members of the health care community should collaborate with other industries and government to develop health care information technology that is compatible with the

emerging national information infrastructure that would link, through a national "information superhighway," institutions and resources throughout the country.

- **Evaluate the usefulness and cost-effectiveness of all data requests**. Regulators, insurers, and others should take responsibility for demonstrating the reliability, validity, usefulness and cost-effectiveness of data sets before requiring that they be collected and reported.

The table below outlines our proposed strategies, identifies a lead organization for each, and estimates the associated time frame and cost.

Summary of Proposed Strategies

STRATEGIES	LEAD ORGANIZATION	TIME FRAME	ESTIMATED COST
I. IMPROVE KNOWLEDGE ABOUT STATE-OF-THE-ART			
I.A. Conduct provider surveys	Computer-based Patient Record Institute (CPRI)	1993-1994	$800,000
I.B. Develop reference model for evaluating costs and benefits of CPR systems	Department of Health and Human Services (HHS)	1993-1996	$3 million
I.C. Analyze information needs and uses in a variety of provider settings	CPRI	1993-1996	$15 million
I.D. Evaluate issues related to organizational, professional and personal change	CPRI	1993-1996	$3 million
II. DEVELOP NATIONAL STANDARDS			
II.A. Promote development, adoption and use of health information standards			
II.A.1. Fund HISPP standards planning and coordination	HHS	Ongoing	$100,000/year
II.A.2. Develop, test and promote use of a patient data set for emergency purposes	Healthcare Informatics Standards Planning Panel (HISPP)	1993-1995	$500,000
II.A.3. Develop standards for the content of the patient record	HISPP	1993-1996	$100,000

STRATEGIES	LEAD ORGANIZATION	TIME FRAME	ESTIMATED COST
II.A.4. Compare and contrast coding schemes and develop needed coding schemes	HISPP	1993-1996	$500,000
II.A.5. Develop uniform provider, payer and patient identifiers	HISPP	1993-1994	$50,000
II.A.6. Foster development of standards certification process	CPRI	1993-1994	$50,000
II.B. Establish national legal standards for protecting the confidentiality of patient information	Congress/President	1993-1994	
II.C.1. Evaluate existing data sets	HHS	1993-1996	$1.5 million/yr
II.C.2. Enact legislation requiring federal agencies to demonstrate the usefulness and cost effectiveness of any mandated data set	Congress/President	1993-1995	
III. DEVELOP LINKAGES BETWEEN EXISTING AND FUTURE COMPUTER-BASED INFORMATION SYSTEMS			
III.A. Encourage development of community health information networks	HHS/CPRI	1993-1996	$25 million
III.B. Collaborate with other industries and government to create the health care component of the National Information Infrastructure	CPRI	1993-ongoing	
TOTAL COSTS		1993-1996	$54.4 million

Implementation Timeline

Below, we have attempted to lay out an estimated timeline for widespread, national implementation of CPR systems and the health information infrastructure. Although a timeline suggests a sequential process of development and implementation, we expect many of the components to be developing simultaneously.

YEARS 1 - 4
Standards. The most important step toward the implementation of computer-based patient records (CPR) is the development and adoption of standards for defining, coding, and transmitting health care data so that information can be shared between systems.

- Adoption of existing standards
- Development of needed standards for defining, coding and sharing patient data
- Enactment of federal legislation protecting confidentiality of patient information
- Development of national standards for the creation, authentication, and storage of patient health records

Research and Development. Also needed is better information about currently implemented systems to help system developers design better systems and to help providers evaluate their system needs. We believe this can be supplied by an aggressive program of demonstrations and evaluation.

- Development of models for evaluating CPR systems
- Demonstrations of emerging CPR systems
- Early demonstrations of linkages between users of patient information within communities
- Continued development of decision support tools (e.g., practice guidelines, performance indicators)
- Development of strategies for training health care professionals in the use of CPRs

YEARS 3 - 10
Evaluation and Initial Implementation. Once standards have been adopted and information has been made widely available about the attributes of successful systems, we expect community health information networks to become more widespread, and systems to become more responsive to user needs. Demand will increase accordingly and systems will proliferate.

- Continued development and adoption of standards
- Replication and evaluation of demonstrations of CPR systems and community networks
- Dissemination of information about successful implementation of CPR systems and community networks
- Increased use of knowledge based systems and reference data bases (for direct patient care, outcomes analysis, etc.)
- Increased focus on CPRs in education and training of health care professionals
- Greater use of high speed communication highways for health care applications

YEARS 9 - 15 AND BEYOND
National health information infrastructure. Realization of the full potential of computer based record systems demands not only that information be captured and stored in computers but that it be accessible to authorized users across time and place. A national high speed

communication highway is needed to enable all participants in the U.S. health care system to communicate electronically.

- Widespread acquisition and implementation of CPR systems
- Widespread establishment of community information networks
- Ongoing refinement and integration of CPR systems, knowledge based systems, and reference data bases
- National availability of high speed communication highway

Chairman STARK. Dr. Clowe.

STATEMENT OF JOHN L. CLOWE, M.D., PRESIDENT, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY DAVID L. HEIDORN, DIVISION OF FEDERAL LEGISLATION

Dr. CLOWE. Mr. Chairman and members of the subcommittee, my name is John L Clowe, M.D., and I am a family physician from Schenectady, N.Y., and president of the American Medical Association. Accompanying me is David L. Heidorn, J.D., of the AMA's Division of Federal Legislation.

The AMA appreciates this opportunity to share its views on bringing about administrative simplification in the health care delivery system. This is vitally important to physicians. Not only do we see significant cost savings, we also see that the ridiculous amounts of time we now spend on administrative hassles and the bureaucratic second guessings of our decisions could be much better spent in the care of our patients.

Complexities and paperwork requirements of the current insurance system frustrates our patients as well. All private insurers and the self-insured should be required to use a single, uniform claim form and a standardized format for electronic claims processing. It is estimated that $5.7 billion a year in health care spending can be saved.

The AMA is participating in the work group of electronic data interchange called WEDI, which was established to achieve consensus on a state-of-the-art electronic data interchange, EDI system. WEDI's efforts are promising, but many questions still exist. Change is imminent, but it is not possible overnight.

Implementation of EDI should be encouraged through tax incentives and other policies. A mandate would force providers to incur sudden costs that will only result in increased health care spending.

Now, without a mandate, the percentage of physicians whose practices submit claims electronically rose from 42.2 percent to 49 percent in only one year, from 1991 to 1992, and we have no doubt in our minds that this trend will continue.

The AMA is also concerned with the hassles and costs of conflicting utilization review practices and managed care requirements. Utilization review standardization can save $2.1 billion a year. Physicians understand fully the need for accountability, especially to their patients, but a physician should not have to spend office time away from patients on the phone telling an unknowledgeable reviewer how to pronounce and spell diagnoses. The care of patients should not have to be delayed because of burdensome precertification requirements in many health plans.

Disclosure of medical review criteria used by PROs is necessary, and physicians must be involved in their development. If physicians knew what the review criteria were, they could change their practice patterns if appropriate. Compliance, therefore, would increase, thus saving costs.

Utilization review should also be opened under managed care. Physicians look at much of what managed care offers today and have difficulty seeing that as reduced or simplified administrative burden. Managed care review criteria should be developed with the

physicians who work within the managed care arrangements. Physicians, not business managers, must have the ultimate responsibility for determining medical care.

To this end, the AMA supports the development of national managed care and utilization review standards and a national accreditation or certifying process. We are pleased with HCFA's new PRO Fourth Scope of Work under which the PRO program is being redirected away from micromanagement toward assisting physicians and hospitals to improve care.

HCFA also has made great progress recently in standardization payment policies under Medicare. WEDI's movement toward EDI is also very hopeful. We may not agree with everything WEDI recommends, but its efforts are an excellent example of the cooperation and the partnership that is possible in the health care industry.

In conclusion, we urge the subcommittee to consider that solutions are already being formulated to simplify and reduce the administration of health care. The government should not try to duplicate or supplant these efforts. Instead, it should help ensure that these efforts are successful in partnership with physicians and others dedicated to successful health system reform.

Thank you, Mr. Chairman.

Chairman STARK. Thank you, Doctor.

[The prepared statement and attachment follow:]

Statement

of the

American Medical Association

to the

Subcommittee on Health

Committee on Ways and Means

U.S. House of Representatives

May 25, 1993

RE: Health Care Reform -- Administrative Simplification

Mr. Chairman and Members of the Subcommittee:

My name is John L. Clowe, MD. I am a family physician from Schenectady, New York, and President of the American Medical Association (AMA). Accompanying me is David L. Heidorn, JD, of the AMA's Division of Federal Legislation.

The AMA appreciates this opportunity to share its views on bringing about administrative simplification in the health care delivery system. Simplification and standardization in the way health insurance claims are processed, patient records are handled, and utilization review is conducted can bring about significant cost-savings. But for physicians, bringing about administrative simplification also means that they will someday be able to devote to the care of their patients the significant time and resources they now expend on repetitive, confusing administrative "hassles" and unnecessary second-guessing of their professional decisions.

This nation is closer than we have ever been to effecting a comprehensive reform of our health care delivery system that can bring necessary, affordable health care to all Americans. Not least of the questions that must be answered in the reform debate is, how do we reduce the administrative burden now weighing down and, in many instances, stifling the health care delivery system?

Physicians are concerned that, with all the talk of administrative simplification from every direction, we may be pursuing reform that only shifts, or even exacerbates, the administrative burden. Much of the discussion about health system reform is now centered on managed competition, which appears aimed at extending managed care principles across the health care system. Managed competition may help limit costs and expand access, but only if there are certain guarantees that there will, in fact, be competition among different kinds of health care delivery methods, not only among different large HMO-like entities.

Physicians look at much of what managed care offers today and have difficulty seeing that it has reduced or simplified administrative burdens. Managed care typically offers a one-time cost savings, which may be the result more of careful patient selection and a severe ratcheting down of provider payments in an unbalanced, unfair marketplace than from true cost-effectiveness. The added cost of bureaucratic management necessary to put limits on and second-guess the choices of physicians and their patients may only be supplanting any cost savings that might be achieved by such intrusions.

Physicians do not believe that health system reform will work if it is based on the unproven assumption that managed care is the only way health care resources can be used efficiently. As in any other part of our society, efficiency is best achieved through plurality in

competition. Our commitment is to work with Congress and the Administration to ensure that the principles of true competition can be made to work in the health care system.

One of the key areas in which government can help ensure the health care system works competitively and efficiently is by working in partnership with all those involved in health care -- physicians, hospitals, other providers, insurers, and consumers -- to bring about administrative simplification. This is already occurring. The AMA is a full participant in the Workgroup for Electronic Data Interchange (WEDI), which has brought together representatives from throughout the health care industry to cooperate in mobilizing the industry's use of technology to streamline the administration of health care.

While we may not agree with everything this group recommends, we believe the process is indicative of the kind of cooperation and partnership that must occur if meaningful change in the way our health care system is administered can be brought about. Significant reductions in administrative burdens are possible, but only through consensus and partnership.

As with all the changes that must be brought about if we are to achieve comprehensive reform of the health care system, we ask that physicians be involved. Those whose ability to practice quality medical care is affected by burdens of administration must be a part of the consensus that brings about change.

Health Insurance Claims Processing

A multitude of complex insurance regulations and paperwork requirements have developed under the current insurance system. This administrative labyrinth frustrates patients and physicians alike, can hinder prompt delivery of needed care, and contributes significantly to the cost of health care. The AMA's own proposal for health system reform suggests a series of specific solutions, including requiring all private insurers and self-insured firms to use a single, uniform claim form and requiring a standardized format for electronic claims processing, which can save $5.7 billion a year alone according to an actuarial study of the AMA's health system reform proposal conducted by Lewin-VHI.

In many respects, the WEDI group may be close to achieving some consensus for establishing a state-of-the-art system for electronic data interchange (EDI), as well as dealing with attendant issues such as establishing standards for EDI, creating incentives for increased use of EDI, protecting patient and consumer confidentiality, and coordinating benefits and health insurance cards, including the establishment of electronic health insurance cards. Many questions still exist, however, and the AMA has certain concerns that we urge the Subcommittee to take into consideration as it deliberates over this complex issue.

A major concern is over how such a system will be implemented. Although change is imminent, it is not possible overnight. Any implementation of EDI should reflect that reality, and be encouraged through tax incentives and other policies. If the goal is to control costs and lessen administrative burdens, implementation should not unnecessarily force providers to incur sudden costs, which will only result in increased health care spending. The AMA cannot support mandatory implementation of EDI.

Attached to this statement is a recent study of the extent of electronic billing among physicians. Without a mandate, without incentives other than cost-savings and simplicity, the percentage of physicians whose practices submit claims and have electronic billing capabilities has increased from 42.2 percent to 49 percent in only one year, from 1991 to 1992. We have no doubt that trend will continue. The marketplace and competition is creating this movement. Any government involvement should help encourage this movement, not preempt it.

The Health Care Financing Administration (HCFA) has been involved in standardizing payment policies under Medicare, including billing and reporting requirements. The AMA takes this opportunity to commend these efforts and encourages HCFA to continue them. It is an excellent example of the kind of positive influence government can have in bringing rationality to the complexities of health care financing and reimbursement.

Utilization Review Standardization

As part of its health system reform proposal, the AMA also has proposed to amend federal and state laws to regulate third-party utilization review and managed care programs to reduce the "hassles" and the costs of various and conflicting managed care requirements, claims procedures, review practices, and disclosure policies. Lewin-VHI has estimated that standardization in utilization review can save $2.1 billion a year in health care costs.

Physicians are not opposed to reasonable oversight or review. Physicians understand fully the increasing need for accountability, especially to their patients. Physicians are opposed, however, to reviews conducted by individuals who are not familiar with medical practice. A physician should not have to spend ten minutes on a phone telling a reviewer how to pronounce and spell the diagnosis the reviewer called the physician to question, which actually happened to a physician member of the AMA. Physicians are also opposed to review processes that place saving money over quality medical care, or are established without cooperation of physicians and organized medicine. This is especially aggravating to physicians because there are alternatives that work and are less costly.

The AMA believes there is a fundamental need to require disclosure of medical review criteria and physician involvement in the development of such criteria. Third-party payer methodologies for determining medical necessity should be made available to medical societies and to individual physicians. Review criteria must be made available to physicians upon request so that physicians are aware of the standards used by utilization review firms in their decision-making processes. Physicians then, as appropriate, can change their practice patterns to meet those criteria. This level of openness would reduce the cost of conducting reviews, because compliance would be increased and the need for enforcement by utilization firms would be diminished.

As with the other issues impacting administrative simplicity, it is essential that review criteria be based on a reliable synthesis of current professional knowledge as determined by active practitioners, representatives of organized medicine, and practice parameters developed by the medical profession. Such a process should also ensure that the criteria are updated on a regular basis, reflect increased scientific knowledge, improved technologies, availability of resources, and other developments relating to the demand for and provision of medical care.

In addition, physicians who are reviewers should be licensed in the state in which the services they are reviewing are performed, and the ultimate reviewer should be in the same specialty as the physician who provided the care, or have the type of care fall within their field of expertise. The availability of such expertise ultimately saves unnecessary levels of unknowledgeable review. In all respects, doctor-to-doctor communications should be encouraged.

Utilization review should also be open under managed care. Consistent review criteria that are acceptable to and have been developed in concert with the medical profession and the physicians working within a managed care arrangement must be established. Physicians, not business managers without medical training, must have the ultimate responsibility for determining the necessity and quality of care.

The AMA has been a full participant in the Utilization Review Accreditation Commission's (URAC) process to facilitate refinement of national utilization review standards. Although the URAC national standards represent an encouraging first step, additional managed care standards need to be developed that are beyond the scope of URAC.

Accordingly, the AMA can support the development of national managed care and utilization review standards and the creation of a national managed care/utilization review accrediting or certifying process based on the national standards that are developed. In addition, the AMA is pleased with the direction the Health Care Financing Administration (HCFA) has taken in this area with Medicare. In particular, we commend HCFA on actively involving the AMA and representatives of the hospital and beneficiary communities in the development of the new Peer Review Organization (PRO) Fourth Scope of Work.

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Under the new scope, which began April 1, 1993, the PRO program will undergo a fundamental change in which PRO review will be redirected away from dealing with individual clinical errors toward assisting physicians and hospitals improve the "mainstream" of care through variations research and principles inherent in continuous quality improvement. For physicians, this is greatly preferable to the previous ways PROs conducted reviews. It is our hope this can be expanded to other review areas.

Conclusion

Recent developments in the establishment of EDI and the redirection in how medical review is being conducted are promising. Efforts are already focusing on electronically simplifying the administration of health care and on improving health care delivery without arbitrary inspections to correct individual errors. Physicians have already taken the first steps into a new frontier in the way medicine is practiced, through efforts that mirror the profession's long history of voluntary efforts to improve continually the quality of medical care.

We urge the Subcommittee to consider that solutions are already being formulated to simplify and reduce the administration of health care. Government should not unnecessarily try to duplicate or supplant these efforts, but, in partnership with physicians and others dedicated to effecting health system reform, help ensure that these efforts are successful.

Studies on the Socioeconomic Environment of Medicine

Electronic Billing of Physician Services

by Anita J. Chawla

Reducing the level and growth rate of health expenditures has become a primary goal of most health system reform proposals. While there is considerable debate on the extent to which administrative costs contribute to health care cost inflation, most policy analysts would acknowledge that streamlining the administration of health care services would provide at least a one-time reduction in administrative costs. It has been suggested that one area in which administrative cost savings could be achieved is the billing for providers' services and submission of insurance claims. The application of electronic transmission of data, bills, and claims between providers and third-party payers could be one source of administrative cost savings.

Administrative Costs and Electronic Billing

Promotion of electronic billing and claims submission as a means to reduce administrative costs has received increased attention since the publication of the Workgroup for Electronic Data Interchange (WEDI) report to the Secretary of the Department of Health and Human Services in July 1992. The WEDI report was a product of a private sector initiated workgroup convened in response to Secretary Sullivan's challenge to industry to address the reduction of administrative costs. In addition to reviewing the state of electronic data interchange in the health care industry, the WEDI report proposed objectives and an action plan to foster widespread adoption of electronic data interchange within the next five years.

Currently, electronic claims submission is far more prevalent for Medicare services. The Health Care Financing Administration estimates that close to 80% of claims for hospital services and 45% for physician services are submitted electronically.[1] The percentage of providers submitting claims electronically in the Medicaid program varies from state to state, with as few as 35% of physicians and as many as 90% of hospitals using electronic claims submission in some states. Blue Cross and Blue Shield estimates that among its plans, more than half of hospital claims (79% of Medicare Part A claims and 60% of private sector hospital claims) are transmitted electronically. Electronic submission of claims for physician services is less than for hospital services with only 50% of Medicare Part B and 20% of private sector physician claims submitted through electronic data interchange. There is a much lower incidence of electronic data interchange in claims submission among commercial carriers. It is estimated that, in 1991, only about 10% of commercial indemnity claims were submitted electronically.

Electronic Claims Capability in Physician Offices, 1991 and 1992

The American Medical Association has recently begun to collect information on physicians' electronic billing capability in their practices using the Socioeconomic Monitoring System (SMS) survey. Results that characterize electronic billing activity in physician offices from the 1991 and 1992 core sur-

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Table 1. Electronic Claims Submission in Physician Offices, 1991-1992[a]

	1991	1992
Percentage of physicians whose practices submit claims and have electronic billing capability	42.2%	49.0%
Percentage of physicians who treat Medicare patients whose practices submit Medicare claims electronically	28.7	38.1
Percentage of physicians who treat non-Medicare patients whose practices submit non-Medicare claims electronically	21.9	29.6

Source: See text of article.
[a] The differences between 1991 and 1992 are statistically significant (p<.01).

veys are presented in this report.[2] The results presented here are derived from a sample of physicians who practiced at least some fee-for-service medicine. Physicians responding to the SMS survey were asked if their practices submit insurance claims directly to third-party carriers. Those who submitted claims directly were asked if their practices had the capability to submit insurance claims to third-party carriers electronically. While SMS survey data on physician office electronic billing is thus far only available for the years 1991 and 1992, the data indicate that physicians are increasingly choosing to acquire the capability to submit claims electronically. The percentage of physicians who submit claims directly to third-party carriers and whose practices have the capability of billing claims electronically increased from 42.2% to 49.0% between 1991 and 1992.

Physicians who submitted claims directly and had electronic billing capability were asked if they submitted claims electronically to Medicare and non-Medicare carriers. Among Medicare providers (services provided in the last 12 months) with electronic billing capability, the percentage of physicians who submitted Medicare claims electronically increased from 28.7% to 38.1%. During the same period, among physicians who provided services to non-Medicare patients and had electronic billing capability, the percentage that electronically submitted claims to non-Medicare carriers increased

Table 2. Percentage of Physicians Who Submit Claims Directly to Third-Party Carriers and Whose Practices Have Capability of Billing Claims Electronically, by Selected Characteristics, 1992

All Physicians	49.0%
Specialty[a]	
General/Family Practice	48.3
Medical Specialties	52.7
Surgical Specialties	51.0
Other Specialties	39.6
Region[a]	
Northeast	40.2
North Central	51.1
South	54.9
West	46.7
Location[a]	
Nonmetropolitan	56.3
Metropolitan less than 1,000,000	52.0
Metropolitan 1,000,000 and over	44.1
Employment Status	
Employee	51.8
Self-Employed	48.1
Practice Size[a]	
Solo Practice	36.3
Two Physician Practice	46.3
Three Physician Practice	59.6
4-8 Physician Practice	61.8
Over 8 Physician Practice	70.2
Age[a]	
Less than 40 years	52.7
40-45	51.6
46-55	51.4
56-65	43.5
More than 66	28.7

Source: See text of article.
[a]Differences are statistically significant (p<.01).

from 21.9% to 29.6%. The increases in electronic billing capabilities during the 1991 to 1992 period, detailed in Table 1, are all statistically significant (p<.01).

Electronic Claims Capability in Physician Offices, 1992

Table 2 shows the percentage of physicians who have the capability of billing claims electronically across a variety of physician characteristics. Over

50% of physicians in medical and surgical specialties have such a capability. Physicians in specialties other than general/family practice, medical and surgical specialties are the least likely to have electronic billing capability. Physicians who have electronic billing capability are more likely to be located in the south than in other regions, and they are more likely to be located in nonmetropolitan areas. Nearly 55% of physicians in the south had electronic billing capability compared with only 40% in the northeast. Physicians in large metropolitan areas are far less likely to have electronic billing capability (44.1%) than those in nonmetropolitan areas (56%).

There are distinct differences in electronic billing capabilities according to employment status and practice size. Only 48% of self-employed physicians, compared with 52% of employee physicians, have electronic billing capability in their practice. The relationship between practice size and billing capability is even more dramatic. Physicians in large practices are far more likely to have electronic billing capability. In practices with more than eight physicians, 70% reported having the capability to bill electronically. Among those in solo practice, only 36% reported having electronic capability. The cost of acquiring the hardware and software required for electronic claims submission is a significant obstacle for smaller practices and for physicians who are not employees. In smaller practices, the costs are likely to be spread among few physicians while in large group practices physicians may not directly bear the costs of acquiring electronic data interchange technology. Furthermore, in smaller practices it is less likely that non-physician office staff would be familiar with electronic data interchange; costs associated with training personnel also represent a significant obstacle to implementing electronic claims transmission. Thus, electronic claims submission may not be cost effective for a number of physician practices, particularly those that are small.

Younger physicians are most likely to have electronic billing capability in their practices. Fifty-three percent of physicians under 40 years of age reported having a capability. Among physicians over 66 years of age, only 29% indicated their practices did so.

The likelihood that a physician would have electronic billing capability would be expected to vary according to the proportion of services provided to patients with different health insurance coverage. Electronic data interchange for claims submission has been promoted most aggressively by HCFA for reimbursing providers for Medicare services. The SMS data shown in Table 3 indicate that the greater the percentage of a physician's revenue from Medicare, the more likely the physician is to have electronic billing capability. Slightly less than 57% of physicians with over 40% of their practice revenue derived from Medicare have electronic capability in their practice. Only 36% of those with 10% or less of their revenue from the provision of Medicare services have electronic billing capability.

Table 3. **Percentage of Physicians Who Submit Claims Directly to Third-Party Carriers and Whose Practices Have Capability of Billing Claims Electronically, by Percent of Revenues from Selected Third-Party Payers, 1992**

All Physicians	49.0%
Percentage of Revenue from Medicare[a]	
0-10%	36.0
11-25%	49.3
26-40%	57.4
More than 40%	56.8
Percentage of Revenue from Blue Cross/Blue Shield[b]	
0-10%	46.2
11-25%	50.4
26-40%	55.2
More than 40%	45.7
Percentage of Revenue from Other Payers[a]	
0-10%	50.7
11-25%	56.6
26-40%	49.2
More than 40%	41.3

Source: See text of article.
[a]Differences are statistically significant ($p<.01$).
[b]Differences are statistically significant ($p<.10$).

The percentage of physicians having electronic capability varies with the percentage of revenue from Blue Cross and Blue Shield. While these variations are statistically significant, the relationship between the proportion of revenue and the likelihood of having this capability is not as clear as is for revenue from Medicare. For example, physicians who receive more than 40% of their revenue from Blue Cross and Blue Shield (BCBS) are less likely to have electronic billing capability than those receiving 11-25% and 26-40% of their revenue

Table 4. **Percentage of Physicians Who Provided Services to Medicare Patients in the Last 12 Months that Submitted Claims to Medicare Electronically, 1992**

	Percent
All Physicians	38.1
Specialty[b]	
General/Family Practice	38.1
Medical Specialties	41.2
Surgical Specialties	39.3
Other Specialties	31.1
Region[a]	
Northeast	30.1
North Central	41.8
South	42.7
West	34.9
Location[a]	
Nonmetropolitan	47.4
Metropolitan less than 1,000,000	41.6
Metropolitan 1,000,000 and over	32.2
Employment Status	
Employee	41.1
Self-Employed	37.2
Practice Size[a]	
Solo Practice	25.5
Two Physician Practice	33.8
Three Physician Practice	45.1
4-8 Physician Practice	52.6
Over 8 Physician Practice	62.1
Age[a]	
Less than 40 years	40.5
40-45	40.9
46-55	41.9
56-65	31.7
More than 66	19.7

Source: See text of article.
[a]Differences are statistically significant ($p<.01$).
[b]Differences are statistically significant ($p<.05$).

Table 5. **Percentage of Physicians Who Provided Services to Non-Medicare Patients in the Last 12 Months that Submitted Claims to Non-Medicare Carriers Electronically, 1992**

	Percent
All Physicians	29.6
Specialty	
General/Family Practice	31.2
Medical Specialties	30.1
Surgical Specialties	30.5
Other Specialties	25.8
Region[a]	
Northeast	22.1
North Central	37.3
South	32.2
West	25.0
Location[a]	
Nonmetropolitan	39.7
Metropolitan less than 1,000,000	31.6
Metropolitan 1,000,000 and over	24.4
Employment Status[a]	
Employee	36.7
Self-Employed	27.5
Practice Size[a]	
Solo Practice	16.7
Two Physician Practice	25.9
Three Physician Practice	42.3
4-8 Physician Practice	37.7
Over 8 Physician Practice	54.8
Age[a]	
Less than 40 years	32.2
40-45	30.4
46-55	33.3
56-65	24.4
More than 66	14.5

Source: See text of article.
[a]Differences are statistically significant ($p<.01$).

from BCBS, but are about as likely to have a capability as physicians with 0-10% of their revenue from BCBS.

Electronic Claims Submission of Medicare and Non-Medicare Claims, 1992

Table 4 shows the likelihood of electronic claims submission of Medicare claims for Medicare providers with electronic data interchange capability. In 1992, 38.1% of Medicare providers who could submit claims electronically from their offices did so. The incidence of electronic claims submission among physicians who provided non-Medicare services and could submit claims electronically was much lower (Table 5).

Among physicians who provided Medicare services, those in medical specialties were more likely to

Table 6. **Proportion of Medicare and Non-Medicare Claims Submitted Electronically, 1992**

	1-25%	26-50%	51-75%	76-100%
Percentage of physicians submitting Medicare claims in this proportion (among physicians who treat Medicare patients)	4.4	2.8	7.2	85.6
Percentage of physicians submitting Non-Medicare claims in this proportion (among physicians who treat Non-Medicare patients)	31.9	23.2	12.4	32.4

Source: See text of article.

submit claims electronically than physicians in general/family practice, surgical, or other specialties. The percentage of physicians who provided non-Medicare services and electronically submitted claims to non-Medicare carriers did not vary significantly according to specialty.

For both Medicare and non-Medicare providers who submitted claims electronically, there were statistically significant differences, among regions, locations, and practice sizes, in the percentage of physicians submitting claims electronically. The patterns of variation are somewhat different. For Medicare providers, physicians in the south and nonmetropolitan areas were more likely to submit claims electronically. Among those providing non-Medicare services, a greater percentage of physicians located in the north central region and nonmetropolitan areas submitted claims electronically to non-Medicare carriers. In general, for both Medicare and non-Medicare providers, physicians in larger practices were more likely to submit claims electronically. The relationship between practice size and the likelihood of submitting claims electronically is particularly strong for Medicare providers submitting Medicare claims.

The use of electronic claims submission in physician offices is more widespread for Medicare services than for non-Medicare services. Table 6 shows that, among physicians who submitted claims electronically to Medicare, 86% submitted between 76% and 100% of their Medicare claims electronically. Physicians who treated non-Medicare patients submitted smaller shares of their non-Medicare claims electronically. Only one-third of these physicians submitted 76-100% of their non-Medicare claims electronically; nearly the same percentage submitted 1-25% of their non-Medicare claims.

In part, the difference in the extent to which physicians use electronic claims submission for Medicare and non-Medicare claims probably reflects higher implicit costs associated with electronic data interchange with non-Medicare carriers. In addition to actively promoting electronic claims submission for Medicare services, HCFA has standardized the format for submission. There is a myriad of submission formats among private sector third-party payers, and physicians argue that the multiplicity of formats contributes to the "hassle factor" of practicing medicine.

1. All figures presented in this section are from the *Report to Secretary of U.S. Department of Health and Human Services* (Washington, D.C. Workgroup for Electronic Data Interchange) July 1992.

2. Some data on electronic billing from the SMS 1991 core survey have been presented in American Medical Association Center for Health Policy Research, "Electronic Billing of Insurance Claims for Physician Services" *Physician Marketplace Update* 3 (March 1992).

Chairman STARK. Ms. Fox.

STATEMENT OF ALISSA FOX, EXECUTIVE DIRECTOR, CONGRESSIONAL RELATIONS, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Ms. FOX. Thank you, Mr. Chairman and members of the subcommittee. I am Alissa Fox, here on behalf of the Blue Cross and Blue Shield Association. Accompanying me today is Jim Christie, also from the association.

As the largest provider of private health insurance coverage in the United States, Blue Cross and Blue Shield plans have a major interest in working to reduce administrative costs to assure the most effective use of health care resources.

We are proud of our performance. In 1991, our administrative costs in the aggregate were 10 percent of total premium. When taxes are excluded, our administrative costs were 9 percent.

While we are proud of our performance, we can and should do better. Our goal is to have a paperless system and to eliminate many of the hassles our current administrative system places on consumers and providers, and that goal is becoming a reality. We have moved aggressively both as cochair of WEDI, the work group on electronic data interchange, and within the Blue Cross and Blue Shield plan operations to simplify the health care system.

WEDI's mission is to develop and implement a plan for a paperless system. WEDI's steering committee involves a cooperative effort among representatives of key health care players, the government, hospitals, doctors, insurers and consumers.

Last year, when we testified on administrative simplification before this subcommittee, we discussed an ambitious set of goals. Today, I am pleased to report that the industry is already beginning to achieve these goals without any prompting from legislation.

Numerous large-scale administrative simplification projects are already underway. By 1996, the United States will have a virtually paperless claims processing system. Last year, WEDI recommended steps to make electronic data interchange routine for the health care industry, including standardization of data formats, automation of health care transactions, uniformity of data content and the development of demonstration projects to test WEDI's ideas. These initiatives have a projected savings of $14 billion per year. WEDI is continuing to work to refine these recommendations and oversee their implementation.

In addition to our participation with WEDI, Blue Cross and Blue Shield plans are undertaking specific initiatives. The proportion of paperless claims handled by Blue Cross and Blue Shield plans nationwide have increased dramatically. Today, about two-thirds of all claims are now handled electronically, and just this year EDI USA was launched. It will be the health insurance industry's largest information network and creates the capability for paperless transactions among Blue Cross and Blue Shield plans, other insurers and providers nationwide.

We believe comprehensive reform of the health care system will also result in streamlined administration, specifically insurance standards, standardizing benefit packages and encouraging managed care networks to move from a transaction-to-transaction re-

view to a review of overall practice patterns and patient outcomes will both help to reduce administrative costs as well as provider hassle.

We look forward to working with Congress on these and other health care reform issues. Thank you very much.

Chairman STARK. Thank you.

[The prepared statement follows:]

TESTIMONY OF ALISSA FOX
BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. Chairman, members of the Subcommittee, I am Alissa Fox, Executive Director of Congressional Relations for the Blue Cross and Blue Shield Association (BCBSA).

The Blue Cross and Blue Shield Association, an association of 71 independent Blue Cross and Blue Shield Plans, welcomes the opportunity to address the Subcommittee on administrative simplification of the health care system. We have moved aggressively as co-chair of the Workgroup on Electronic Data Interchange (WEDI) and in Blue Cross and Blue Shield Plan operations to simplify the health care system for consumers and providers, while enhancing our capability to effectively manage costs and improve the quality of care.

Last year, when we testified on administrative simplification before this Subcommittee, we discussed an ambitious set of goals. Today, I am pleased to report that Blue Cross and Blue Shield Plans, along with other insurers, are already achieving those goals -- without any prompting from legislation. Numerous large-scale administrative simplification projects are already underway. By 1996, the United States will have a virtually paperless claims processing system.

I am also pleased to report that projected administrative cost savings resulting from the WEDI initiatives have increased over the past year, from $4 to $10 billion per year to $14 billion per year. The new projections will be documented in WEDI's 1993 report.

The scope of our commitment to administrative simplification and innovative use of electronic data interchange to improve health care is conveyed by a few examples.

- Blue Cross and Blue Shield Plans increased the proportion of paperless claims from 41 percent in 1990 to 61 percent in 1992.

- Blue Cross and Blue Shield of Virginia (BCBSV) is running a WEDI demonstration project which includes approximately 165 hospitals, over 5,000 providers, commercial insurers, Medicare, and Medicaid. Transactions included in the project include claims processing, remittances, eligibility and benefits verification, electronic funds transfer, automated managed care referrals among physicians and payers, electronic mail, and enrollment. BCBSV has connected its network to all participating payers and is currently delivering over 160,000 claims per month to non-BCBSV entities.

- In early 1993, EDI-USA was launched. This is a joint project of Blue Cross and Blue Shield of Kentucky, IBM and the Blue Cross and Blue Shield Association. It will be the insurance industry's largest electronic data interchange network, and creates the capability for paperless transactions among Blue Cross and Blue Shield Plans, other insurers (including Aetna, Equicor and Humana) and providers. These transactions include claims processing, claims status information, benefit and enrollment verification, and electronic remittances.

- King County Medical Blue Shield (Seattle) has developed a joint venture with a banking network which includes most automated teller machines in the Pacific Northwest, a group of physicians and a pathology laboratory. The resulting program will support a full

range of electronic transactions between providers and payers and communications across the provider community, including electronic funds transfer, utilization management, reporting of test results, and electronic mail.

The remainder of our testimony will address three topics: (1) Blue Cross and Blue Shield Plans' administrative costs, (2) ongoing and additional administrative simplification initiatives which the Blue Cross and Blue Shield Association supports, and (3) proposals which we oppose.

BLUE CROSS AND BLUE SHIELD PLANS' LOW ADMINISTRATIVE COSTS

Blue Cross and Blue Shield Plans are proud of their low administrative costs. Even though Blue Cross and Blue Shield Plans are a major source of coverage for small groups and individuals, which have inherently higher administrative costs than large groups, in aggregate, our administrative cost was only 9.0 percent of premiums, exclusive of taxes, in 1991. This figure includes managed care activities, claims adjudication, premium collection, provider payment, marketing, anti-fraud activities, actuarial services, and numerous other functions. Many of these activities promote cost containment. For instance, the Blue Cross and Blue Shield Association's Technology Evaluation and Coverage Program is an acknowledged leader in the field of technology assessment.

When the administrative costs of other industries are examined, our costs compare favorably. In 1991, administrative expenses were 16.3 percent of net revenue for security brokers, 24.1 percent for life insurers, and 36.6 percent for national commercial banks.

ADMINISTRATIVE SIMPLIFICATION INITIATIVES SUPPORTED BY THE BLUE CROSS AND BLUE SHIELD ASSOCIATION

<u>Comprehensive Health System Reform</u>

The Blue Cross and Blue Shield Association supports comprehensive health system reforms which streamline administration, in addition to their other benefits.

Universal insurance coverage would reduce the barriers to care now faced by uninsured persons and decrease providers' collection costs.

Shifting managed care arrangements from transaction-by-transaction, review-to-review of overall practice patterns and patient outcomes would eliminate the "hassle factor" providers and consumers complain about, while enhancing accountability for results. Under Blue Cross and Blue Shield of Michigan's (BCBSM) new partnership with the Henry Ford and Mercy health systems, the systems will conduct their own provider credentialling, utilization management, quality assurance and medical necessity interpretation, consistent with BCBSM standards.

Strict insurance market reform rules, portability of coverage, and reduced variation among benefit packages will facilitate consumer shopping among insurance plans.

Additionally, we expect well-designed health reforms to encourage closer ties between providers and insurers. As a result, within the next few years it is likely that each physician and hospital will, on average, deal with a smaller number of payers than at present.

WEDI-Related Initiatives

Many administrative simplification issues have been addressed through WEDI, an insurance industry-led task force created to streamline health care administration through standardized electronic communications. This year, WEDI's steering committee was expanded to 28 national organizations, including AARP and the National Committee to Preserve Social Security and Medicare. Provider groups and federal and state governments are also represented on the steering committee. Bernard R. Tresnowski, President and CEO of the Blue Cross and Blue Shield Association, and Joseph T. Brophy, representing the Travelers Insurance Company, are WEDI's co-chairs.

WEDI calls for a public-private partnership to achieve reform. The Workgroup envisions administering health care business transactions via computer, using one national standard format and interconnecting networks. Since much of the EDI technology to achieve these goals is already available, WEDI recommends that these communications networks evolve through interconnections among existing and new networks, rather than by creation of a single national architecture.

In July 1992, WEDI recommended steps to make electronic data interchange (EDI) routine for the health care industry. The recommendations encompassed standardization of data formats, automation of health care transactions, uniformity of data content, protection of patient confidentiality, and the development of demonstration projects to test WEDI's ideas. Since that time WEDI and its 200-member Technical Advisory Group have been refining the 1992 recommendations, developing new recommendations, and pursuing demonstration projects. BCBSA positions and Blue Cross and Blue Shield Plans' initiatives are closely linked to WEDI's recommendations.

Implementation of Uniform Claims Forms and Coding Systems

BCBSA, like WEDI, supports uniformity of data content as defined by (1) the UB-92 claims format and coding structures for institutional providers developed by the National Uniform Billing Committee, and (2) the HCFA 1500 claims format and coding structure for professional and community-based providers developed by the Uniform Claim Form Task Force. BCBSA and WEDI support the use of these claims formats and coding structures as a transitional step to implementation of the ANSI X12 EDI standards.

Implementation of On-Line Eligibility and Benefits Verification

On-line eligibility and benefits verification capabilities allow providers to obtain patient insurance and benefit information at the time of service. By streamlining operations in physician offices, hospitals, and other health care facilities, these transactions reduce administrative costs for health care providers.

Many Blue Cross and Blue Shield Plans currently have the capacity to allow providers to verify eligibility and benefits on-line. For example, Blue Cross and Blue Shield of New Jersey has developed a Prescription Drug Claim Entry System that provides on-line eligibility verification and also supports real-time electronic claims processing. The product is available to approximately 1,800 New Jersey pharmacies.

Electronic health insurance cards containing encoded information have been proposed to facilitate eligibility and benefits verification, among other administrative functions. To explore the promise of this technology, several Blue Cross and Blue Shield Plans have invested in test programs involving electronic cards. The tests, thus far, have found electronic cards to be an expensive avenue for eligibility and benefits verification. In general, using cards as a means of accessing on-line eligibility and benefits information may be less costly and more effective than encoding that information on the card. WEDI is developing standards for optional health identification cards that would be used to access the electronic data interchange network.

Completing the Conversion to Paperless Claims

BCBSA supports quickly completing the conversion from paper claims to electronic billing. Blue Cross and Blue Shield Plans are the largest processors of electronic health care claims in the country and are moving aggressively toward a paper-free environment. Approximately 87 percent of our Medicare Part A claims and 69 percent of private hospital claims are handled electronically -- which is roughly a 10 percent increase in both categories over the last year.

Blue Cross and Blue Shield Plans achieved a dramatic increase in electronic processing of private sector physician claims. In 1992, 41 percent of these claims were electronically processed, compared to 20 percent in 1991. Electronic processing of Medicare Part B claims has increased to 61 percent from 55 percent. These increases are the result of aggressive Blue Cross and Blue Shield Plan programs. For example, the Alabama Plan requires that all providers in preferred networks submit claims on behalf of their patients.

Blue Cross and Blue Shield of Minnesota is pioneering the next generation of this technology by integrating electronic claims submission with automated medical review in a system targeted at skilled nursing facilities. The provider enters billing and medical information into the system through a personal computer. The system prompts the user if it finds errors or needs more information. The system then follows the review procedures of a medical review analyst. Within minutes, the provider knows if the claim will be approved or forwarded for medical review. If the system does not affirm the provider's decision, the provider can insert a complete narrative rationale.

Completing the conversion to paperless claims will require a streamlined coordination of benefits procedure. This is a key target of WEDI's 1993 recommendations. WEDI projects that achieving this goal will reduce insurers' claims processing costs by 5 percent to 7 percent. Providers would realize additional cost savings and simplification through reduced resubmission of claims.

Electronic Transfer of Payments to Providers

Electronic transfer of payments directly to health care providers benefits providers by allowing them to maintain a better cashflow with faster posting of their own accounts and less administrative effort to collect payment.

Blue Cross and Blue Shield Plans are leading the way in electronic fund transfer. Many Blue Cross and Blue Shield Plans pay providers electronically, and 13 Plans provide electronic payment and remittance services for commercial insurers. As discussed earlier, the Blue Shield and Blue Shield Plan in Seattle is creating an electronic payment system in conjunction with an automatic teller machine network. The system has numerous applications beyond electronic payment.

Federal Confidentiality Legislation

WEDI's 1992 report urged Congress to enact preemptive legislation governing confidentiality by the end of 1993, to assure the uniform, confidential treatment of identifiable information in electronic environments. Legislation should preserve confidentiality and privacy rights in individually identifiable health care information, and preempt state laws (except public health reporting). We support moving forward with such legislation.

Electronic Medical Records

Electronic medical records hold substantial promise as a quality improvement and cost management technology. Hospitals routinely make some use of on-line service information and a few facilities are developing more comprehensive on-line patient record systems. There is very little experience with electronic medical records outside of the hospital setting.

The very limited experience to date has shown that electronic medical record systems, other than those applied to routine hospital functions, are difficult, time-consuming and expensive to install. Consequently, full implementation of electronic medical records that can be used to improve care and contain costs is a mid- to long-term goal. Key issues which remain to be resolved include: standardizing the data content and format of patient medical records, confidentiality, efficient data entry systems, and how to establish fail-safe data editing and correction systems.

PROPOSALS THE BLUE CROSS AND BLUE SHIELD ASSOCIATION OPPOSES

Regional Claims Consortia

The private sector is aggressively developing regional claims clearinghouses which include the participation of multiple insurers. Thirteen Blue Cross and Blue Shield Plans already provide electronic billing services for commercial carriers. These include the EDI-USA, Blue Cross and Blue Shield of Virginia, and King County Blue Shield initiatives discussed earlier. Other examples include:

- Blue Cross and Blue Shield of Missouri has created a regional joint venture clearinghouse with General American Life, Healthlink and Healthnet to offer electronic claims services for virtually any payer.

- Under a WEDI demonstration project, Blue Cross and Blue Shield of Minnesota and Medica, the state's two largest health plans, are linking their computer networks to increase the number of providers using EDI technology. For the first time, providers will be able to use one computer system to submit claims electronically to Blue Cross and Blue Shield, Medica or commercial carriers.

Government intervention is not needed to create clearinghouses. Private sector activity in this area is extensive, and ANSI standards facilitate further network development.

Standardized Audits and Screens

Insurers use bill audits and screens for a variety of purposes, including verification of appropriate billing for services. We do not believe that audits and screens should be standardized. Standardization would be incompatible with the varying and evolving reimbursement methodologies which characterize our health care system, including performance-related reimbursement. Different payment systems require insurers to examine different aspects of billing patterns when conducting audits and screens. Moreover, standardized audits and screens are likely to lag behind changes in the market.

Superior results will be achieved by competitive development of screens and audits. This places a minimal burden on providers, so long as insurers' systems and providers' office management systems meet ANSI standards permitting electronic communication.

CONCLUSION

The primary goals of health system reform are to achieve universal insurance coverage, contain total health care spending and improve the quality of health care services. At times, achieving our primary goals will require us to invest time and money in administrative services. For instance, Blue Cross and Blue Shield of Minnesota's shift to quality-related payments for hospital care entailed administrative costs and functions that would not have to be performed if the Plan paid the same amount for low quality care as for high quality care. This investment will save on claims costs and improve the quality of care. In summary, our goal should not be the least costly, least complex administration of our health care system; rather, it should be the least

costly, least complex administration consistent with low cost, high quality care and the level of patient services Americans have a right to expect.

It is also important to recognize that important barriers remain to be overcome in advancing the state-of-the-art in administrative simplification. These include up-front capital investments in an increasingly cost-conscious market, confidentiality concerns, legal and regulatory barriers, and occasional provider and consumer resistance to change. Additionally, for small volume providers there is concern that the cost of EDI would exceed the benefits. Our Plans often have addressed this issue through financial incentives, including free or discounted technology and maintenance.

Thank you for the opportunity to share with you our views on administrative simplification and our work to simplify the administrative process while reducing its cost.

Chairman STARK. Mr. Neuschler.

STATEMENT OF EDWARD NEUSCHLER, DIRECTOR, POLICY DEVELOPMENT AND RESEARCH, HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. NEUSCHLER. Thank you, Mr. Chairman and members of the subcommittee.

My name is Edward Neuschler. I am director of policy development and research for the Health Insurance Association of America which represents many of the Nation's leading commercial insurance carriers.

HIAA has long supported efforts to simplify the administration of health insurance plans in order to reduce costs and improve service to our customers. Our goal should be a completely paperless system in which all the information necessary to pay for medical services travels electronically between payers and providers, using a universal standard format and interconnecting networks.

Last year, HIAA formally endorsed the first report from the work group for electronic data interchange, and we have continued to participate actively in WEDI's deliberations, both on its steering committee and in its technical advisory groups. Many commercial insurance companies participate today in clearinghouses that transmit provider claims electronically, and others are participating in various experiments and pilot tests around the country.

As has been said already today, the physical technology necessary to create a paperless health claims system exists now, and we believe that immediate action can and should be taken on the remaining obstacles so that we can move rapidly to realize the efficiencies of a paperless system.

A major hurdle has been overcome within the past year with the formal issuance of draft standards for the electronic transmission of health care information under the auspices of the American National Standards Institute. These standards represent, one might say, the envelope in which health care data can be transmitted from one computer system to another.

WEDI is moving forward now to make recommendations about other pieces that need to be standardized before we can truly say that the infrastructure necessary for a universal paperless system is in place. These include such issues as unique universal identifiers for patients, providers, employers and payers, standard formats for identification cards and firm agreement on the content and definitions for each of the various items of information in the claims record.

As has also been said before, earlier today, Federal legislation will be needed to provide a national standard for protecting the confidentiality of electronically-transmitted medical information and to preempt State laws that would interfere with the operation of a fully electronic system. It is possible that Federal legislation may be useful in some other aspects as well, but I would prefer to wait for the issuance of WEDI's 1993 report, due in 2 months, before commenting on that topic in detail.

Once a fully developed, universal electronic infrastructure is available, we believe its benefits will ensure its use, at least by payers and high-volume providers. As Joe Brophy, WEDI's cochair,

likes to say, the economics here are compelling. But there is no doubt that there will be change-over costs and capital investments required up front, and those costs may discourage some participants, especially smaller providers.

WEDI is currently considering what financial incentives ought to be provided to encourage speedier adoption of electronic data interchange by smaller participants.

In summary, Mr. Chairman, the private sector is firmly committed to simplifying health care administration, both to lower costs and to reduce the hassle factor for providers and patients alike. We believe that the best way to simplify the system is to move as rapidly as possible to a paperless, electronic environment for handling health care claims and related transactions, and we are taking primarily through WEDI the steps necessary to create that environment.

More broadly, HIAA looks forward to working with the President, the Congress and the American people to achieve comprehensive health care reform, including administrative simplification of the system.

We would be happy to answer any questions you may have.

[The prepared statement and attachments follow:]

TESTIMONY OF EDWARD NEUSCHLER
HEALTH INSURANCE ASSOCIATION OF AMERICA

Good morning, Mr. Chairman and Members of the Subcommittee. I am Edward Neuschler, Director of Policy Development and Research for the Health Insurance Association of America (HIAA). HIAA is a trade association which represents many of the leading commercial health insurance companies. I am pleased to appear before you today to discuss issues relating to health care reform and administrative simplification of the health insurance system.

As part of its vision for a society of healthy individuals and communities, HIAA supports comprehensive reform of our health care system. HIAA's vision includes universal, cradle-to-grave coverage, mandates on individuals to purchase coverage and on employers to provide coverage, and guaranteed issue of private insurance coverage.

HIAA supports early federal action to support our mutual goals: achieving universal coverage, controlling health care costs, maintaining quality health care, and assuring the American people that they will have health care when they need it.

Achieving these goals will require fundamental change from everyone--insurers, providers, consumers, and government. It will also require fairness in how these goals are achieved. HIAA believes that adherence to certain guiding principles will facilitate change and make success far more likely.

First, all payers, both public and private, must play by the same rules and pay the true cost of the health care services they purchase. All Americans must have an essential benefit package, with the government subsidizing those who cannot afford to purchase coverage. Insurance market reforms must be adopted. We must build on our employment-based system and require employers to help pay for at least part of the cost of the essential benefit package. Because of this financial commitment, employers must remain actively involved in their employees' health care coverage. Individuals and employers must also retain choice, and they should not be required to purchase insurance only through group purchasing pools. The health care delivery system itself must be changed, with an emphasis on the continued evolution of managed care. There should be an equitable tax policy for health insurance coverage. Individuals must themselves take responsibility for their own health and adopt healthier lifestyles.

Achieving a paperless system is one of a number of steps that will help reduce health care costs. HIAA has long supported efforts to simplify the administration of health insurance plans. We believe that immediate action can be taken to move toward an efficient, paperless system. HIAA supports these efforts both through activities of its member companies and as a member of the Steering Committee of the Workgroup for Electronic Data Interchange (WEDI).

1. Administrative Simplification through Electronic Data Interchange

A vital component of health care administrative simplification is "paperless" processing, also called electronic data interchange, or "EDI." EDI is simply the transmission of data from one location to another via electronic means. Very important to this process are standard formats so that the computers on either end of the transmission can understand one another. An example of what standardized formats can make possible is the widespread use of electronic fund transfers (EFT) in the financial services industry.

The technology to use EDI in the health care industry already exists. There are, however, several major obstacles to more widespread use of EDI. Chief among them has been a lack of standardization among health care transactions. The health care industry has recently achieved consensus among all parties through the adoption of a set of electronic standards to transmit health care information. That standard is the American National Standards Institute's (ANSI) ASC X12 standard. (Note: in 1979 ANSI chartered the Accredited Standards Committee [ASC] X12 to develop uniform standards for interindustry electronic interchange of business transactions.) Industry-wide use of ANSI X12 is important to implementing EDI and reducing administrative costs.

The Workgroup for Electronic Data Interchange (WEDI) is a voluntary, public-private task force created in 1991 to

streamline health care administration through standardized electronic communications. WEDI envisions a health care industry transacting all of its business electronically, using one set of electronic standards and interconnecting networks. In 1992, WEDI submitted a comprehensive report outlining how that vision can be achieved. Just over a year ago (in April 1992), Mr. Joseph Brophy, President of the Travelers Insurance Company (now retired) and WEDI Steering Committee Co-chairman, provided testimony to this Subcommittee about WEDI and specifically about the details of electronic data interchange in the health care industry. An executive summary from the 1992 WEDI report is attached (attachment 1).

This year WEDI expanded its membership to include 26 national organizations (attachment 2), representing federal and state health care governmental agencies, payers, providers, consumers and business. WEDI's focus is now on the resolution of obstacles to implementing electronic data interchange. In fact, today the WEDI Steering Committee is meeting just across the Potomac in Alexandria to review a draft of its 1993 report, which is expected to be published in July. In March, WEDI addressed preliminary recommendations to the Administration's Health Care Reform Task Force (attachment 3).

2. Obstacles to EDI in the Health Care Industry

The health care industry lags behind other industries, such as the airlines or banking, in its use of EDI. As mentioned above, there are several obstacles to the more widespread use of EDI within health care. As also noted earlier, reaching agreement on the ANSI X12 standard for electronic formats is a major step forward, but consensus is needed on various other technical components before a complete EDI infrastructure is ready for use.

For example, an EDI system requires identifiers to transmit data among participants. These are analogous to the unique addresses telephone systems or postal systems need in order to know exactly where each transmission is to be sent. A commonly accepted unique address or EDI identifier is needed for each patient, payer, provider and employer.

Another obstacle involves the very sensitive issue of confidentiality of patient information in an electronic environment. The electronic submission of all administrative and clinical health care data must consider the confidential nature of such information. Today, the majority of such data is documented on paper, and state laws protecting the confidentiality of the information reflect the paper nature of the documents. Because electronic transmissions often cross state boundaries, and because electronic records face different threats to confidentiality than paper records, Federal legislation is needed to preempt state laws and set national standards for handling confidential information.

A third obstacle to the more widespread use of EDI is a lack of consistency in the content of the data which is being transmitted. Not only is there inconsistency between public and private payers, there is also inconsistency within the federal programs: the Medicare and Medicaid programs have not followed the same standards for the data content involved in physician billing.

Lastly, and most importantly, the participants in the health care industry must agree to use EDI. This is a huge challenge because of the diversity of the tens of thousands of organizations, ranging from small physicians' offices or rural hospitals to major hospitals and Fortune 500 employers, that must be part of a large EDI infrastructure. For example, one impediment to immediate use of EDI is that presently only one-third of physician offices in the U.S. are automated. Without financial incentives, these small businesses may not be equipped or prepared to move voluntarily toward EDI. Another problem is the relative complexity of the data involved in health care transactions. Much more information is included on a health care claim than in, e.g., an electronic funds transfer between bank accounts or an airline reservation. The WEDI preliminary report

to the Administration's Health Care Reform Task Force outlined high-level recommendations for all of these major obstacles. WEDI's final report for 1993 will provide more specific and comprehensive recommendations.

3. Benefits of EDI

Despite the obstacles still to be overcome, the health care industry continues to work energetically towards completion of an electronic infrastructure for the U.S. health care system, because the potential benefits to payers, providers and consumers are enormous. In addition to administrative simplification and cost reduction, electronic data interchange provides the infrastructure for improved patient care and health care policy decision-making. Though its initial focus is on the data needed to process and pay claims, EDI can evolve to include other health care data, such as clinical data. Other industry groups are looking at computerizing the patient medical record. In time, all health care financing and delivery information will be readily available, leading to better health care decision-making and overall quality of care.

More specifically, the benefits of the widespread use of EDI in the health care industry are:

(a) **Lower Costs**, resulting from reduced administrative staffs for providers and payers. Duplicative activities will be eliminated. Error correction and resolution activities will be reduced because accuracy and quality of data will be improved. The quality of medical decision-making will improve, thereby improving health care delivery and saving money.

(b) **Reduced Hassle**. Much of the paperwork will be eliminated, especially for patients, but for providers as well. Standardized data content and transmission formats will greatly improve efficiency and reduce the hassle and confusion that currently exists.

(c) **Improved Health Care**. Current information will be available to medical decision makers on a much more timely basis. Duplicative or unnecessary tests or procedures can be avoided. There is tremendous potential for improved decision making and better health care delivery.

HIAA looks forward to working with the President, the Congress and the American public to achieve comprehensive health care reform, including administrative simplification of the system. I would be pleased to answer any questions Members of the Subcommittee may have.

Attachment 1

WEDI REPORT

Executive Summary

In November 1991, Secretary of Health and Human Services, Dr. Louis Sullivan, convened a forum of national health care leaders to discuss the challenges of reducing administrative costs in the U. S. health care system. At the forum, three health care industry-led workgroups were created -- the Workgroup for Electronic Data Interchange, The Taskforce on Patient Information, and the Workgroup on Administrative Costs and Benefits.

This report represents the findings and recommendations of the Workgroup for Electronic Data Interchange (WEDI) and reflects the efforts of a genuine public and private partnership over the last six months. Co-chaired by Bernard R. Tresnowski, President, Blue Cross and Blue Shield Association, and Joseph T. Brophy, President, The Travelers Insurance Company, the 15-member WEDI Steering Committee, supported by a technical advisory group of approximately 50 staff, convened to assess and mobilize the health care industry's use of technology to streamline health care financing.

This report has laid out aggressive but achievable goals to propel the health care industry toward the use of EDI quickly and effectively. WEDI has also developed a specific action plan for translating these goals into reality. WEDI believes the answer lies in a public/private partnership. Because EDI represents an opportunity where good public policy and good business sense converge, we believe the industry can and will respond as an effective partner with the government.

WEDI Recommendations

After consideration of the research, analysis, and findings of our six technical advisory workgroups, WEDI is making the following recommendations to promote full implementation of EDI within five years in order to fulfill the goal of reducing administrative costs within the health care community.

Toward that goal, the WEDI process established a forum for private/public partnership on EDI-related activities. WEDI's continued role in strengthening this partnership is integrated in the following recommendations.

I. Public/Private Partnership Reaches Consensus on EDI Implementation

Adopt Standards

The industry shall define and publish standard formats for the following core financial transactions by fourth quarter 1993, through the American National Standards Institute ASC X12 Insurance Subcommittee:

- Enrollment
- Eligibility
- Claims submission
- Payment and remittance advice

Formats for other major business transactions, such as claims inquiry and referrals, should also be developed and be made available as close as possible to the 1993 target date. For those electronic environments using open messaging (electronic mail) to communicate information beyond the standard transactions, all vendors and participants are expected to use CCITT X.400 open messaging standards.

Recommendation #1 from the WEDI Report

Automate Transactions

By fourth quarter 1994, 95% of Category I industry participants should implement EDI, directly or through a clearinghouse, for those core transactions listed above, offering the ANSI ASC X12 standard formats. Category I participants include major public and private payors; hospitals; major employers and self-insured plans; pharmacies; and clinics and group practices of 20 or more professionals. By fourth quarter 1996, 85% of Category II participants should implement EDI for core transactions, directly or through a clearinghouse, phasing in ANSI ASC X12 standard formats. Category II participants include all remaining health care payors; providers; employers and self-insured plans; and pharmacies. A longer phase-in period may be necessary for small employers implementing electronic enrollment transfer to payors.

Recommendation #2 from the WEDI Report

Between now and fourth quarter 1995, WEDI shall submit periodic reports to the Secretary regarding progress in achieving implementation percentage goals. If the industry has failed to make satisfactory progress in reaching these goals, WEDI will recommend that the Secretary take further action, including appropriate legislation to support these voluntary initiatives.

Recommendation #3 from the WEDI Report

Provide Incentives

Public and private payors should create incentives for increased use of EDI. Among the incentives available are: low- or no-cost software and maintenance support, quick payment incentives for electronic claims, cost/benefit analyses, and technical assistance. In addition, providers and other participants are urged to explore opportunities for partnerships to reduce development and implementation costs. For example, hospitals may provide electronic links to physicians to facilitate access to automated coding. Providers may create "informational partnerships" that reduce the development, transitional, and operating costs of EDI and avoid duplication of effort.

Recommendation #4 from the WEDI Report

To facilitate the necessary initial investment by small or rural Category II providers and small employers that may encounter financial hardship in acquiring EDI technology, WEDI recommends the Congress consider tax incentives.

Recommendation #5 from the WEDI Report

Unify Data Content

By 1995, all participants should be committed to full use of standardized billing content for claims submission (including data elements and codes), as developed/revised by the National Uniform Billing Committee (for institutional providers) and the Uniform Claim Form Task Force (for professional and community-based providers). There are no clearly recognizable entities to standardize content for non-billing transactions (such as enrollment and eligibility) and some community-based providers, nor a clear process for developing and coordinating industry-wide implementation guides for formats and content. For these reasons, WEDI will work with ANSI ASC X12 and other health care industry entities to determine a process for accomplishing these goals by fourth quarter 1993.

Recommendation #6 from the WEDI Report

A WEDI task force should be created and will consult with other appropriate industry organizations to determine the feasibility of a unique identifier system that covers all participants in the health care system and a process for implementation by fourth quarter 1993. All participants should adopt the identifiers by fourth quarter 1995.

Recommendation #7 from the WEDI Report

Create Accreditation for Clearinghouses

Clearinghouses should meet minimum performance standards to protect the business, confidentiality, and security of EDI customers. The industry should create a voluntary accreditation program for clearinghouse entities by fourth quarter 1994. WEDI shall include in its 1995 report to the Secretary, an update on whether an effective accreditation program has been created. If not, the Secretary may wish to recommend legislative intervention or other appropriate action.

Recommendation #11 from the WEDI Report

II. Preliminary Savings Estimated at $4 to $10 Billion: WEDI Commits Funds for Further Study

WEDI will sponsor and fund continuing analysis of the benefits and costs of EDI as they relate to reduction in administrative costs. In particular, there is a need for research in the following categories:

- EDI implications for providers and employers, including an analysis of start-up costs and the ongoing impact on administrative costs.
- System-wide EDI investment requirements and implementation costs.

Recommendation #13 from the WEDI Report

III. Call for Congressional Action to Protect Consumer Confidentiality and Privacy Rights

Congress should enact federal pre-emptive legislation governing confidentiality by fourth quarter 1993 to facilitate and ensure the uniform, confidential treatment of identifiable information in electronic environments. WEDI shall create a task force to coordinate with other relevant groups and to assist in the timely technical drafting of this legislation, which should:

- Establish uniform requirements for preservation of confidentiality and privacy rights in electronic health care claims processing and payment;
- Apply to the collection, storage, handling, and transmission of individually identifiable health care data, including initial and subsequent disclosures, in electronic transactions by all public and private payors, providers of health care, and all other entities involved in the transactions;
- Exempt state public health reporting laws;
- Delineate protocols for secure electronic storage and transmission of health care data;

- Specify fair information practices that ensure a proper balance between required disclosures, use of data, and patient privacy;
- Require publication of existence of health care data banks;
- Establish appropriate protections for highly sensitive data, such as data concerning mental health, substance abuse, and communicable and genetic diseases;
- Encourage use of alternative dispute resolution mechanisms where appropriate;
- Establish that compliance with the act's requirements would be a defense to legal actions based on charges of improper disclosure;
- Impose penalties for violations of the act, including civil damages, equitable remedies, and attorneys' fees where appropriate; and
- Provide for enforcement by government officials and private, aggrieved parties.

In addition, a longer-term goal should be the standardization of all legal requirements for record-keeping procedures. WEDI encourages the Sullivan Taskforce on Patient Information to examine more fully the confidentiality issues associated with computerized patient records.

Recommendation #8 from the WEDI Report

IV. Coordination of Benefits and Health Insurance Cards Can Simplify Health Care for Consumers

A three-pronged action plan is proposed:

- WEDI shall create a task force to develop a clear process for application of model COB rules in electronic environments by fourth quarter 1993.
- The health care industry should work with ANSI ASC X12 to create a standard crossover format no later than fourth quarter 1994.

- Participants should utilize a unique identifier system, as cited above in recommendation #7, to facilitate instructional routing of information to support COB.

These three elements can support full implementation of electronic exchange of information for COB.

Recommendation #9 from the WEDI Report

A WEDI task force should be established to develop recommendations regarding the use of electronic card technology by second quarter 1993. The objectives of the task force are to:

- Determine options for using electronic health insurance cards within the health care environment and the types of electronic card alternatives, such as magnetic stripe cards and smart cards.
- Recommend an implementation process to ensure that standard and current information can be accessed.

Recommendation #10 from the WEDI Report

V. WEDI Continues Public/Private Partnership to Provide Leadership and Monitor Implementation

To oversee the industry's progress toward EDI, and to assist in the fulfillment of these recommendations, WEDI shall continue in existence as a collaborative effort among health care industry participants and shall report to the Secretary of DHHS each year on industry progress. By the end of 1992, WEDI shall create and approve a structure for its conduct, including additional membership and administration of the Steering Committee, standing task forces, and public input. Membership and participation in WEDI shall continue to be on a dual level with both executive management and technical support. The WEDI steering committee may be expanded up to 20 voting members to ensure diverse and balanced representation into the future. Technical group representation shall be open to other interested parties.

Recommendation #14 from the WEDI Report

To support critical educational activities and to generate industry support for implementation, WEDI shall develop a work plan on publicity and education to facilitate dissemination of materials and resources for all major participants. WEDI, as a national resource on EDI implementation, shall use its work plan to promote awareness of other industry organizations and activities.

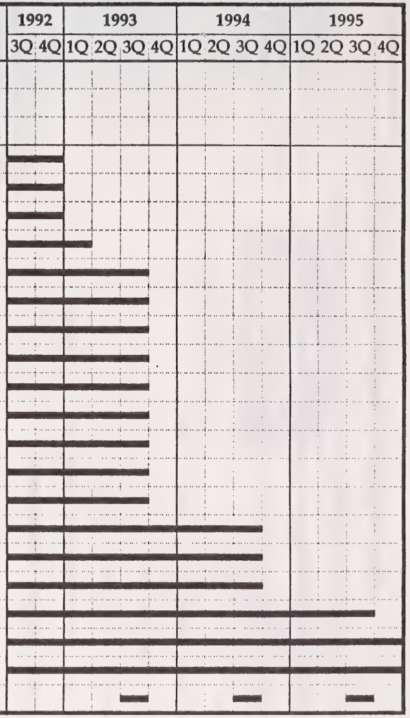
Recommendation #15 from the WEDI Report

Participants should stimulate demonstration projects wherever possible, to highlight new approaches and publicize the uses of EDI in the health care industry.

Recommendation #12 from the WEDI Report

HEALTH CARE INDUSTRY EDI IMPLEMENTATION SCHEDULE
GOAL: FULL EDI AUTOMATION WITHIN FIVE YEARS

Topic	Rec #[A]	Resp[B]	Task
		Government	DHHS forum on administrative costs 11/91
		WEDI	Began analysis of industry's use of EDI 1/92
		WEDI	Made EDI recommendations to DHHS Secretary 7/92
WEDI	14	WEDI	Creates structure for membership/task forces
WEDI	15	WEDI	Establishes work plan for publicity/education
CONFIDENTIALITY	8	WEDI	Drafts model confidentiality federal legislation
ID CARDS	10	WEDI/IND*	Develop recommendations for ID cards
FORMATS	1	Industry	Defines and publishes standard EDI formats
FORMATS	1	WEDI/IND*	Identify system for implementation guides
INCENTIVES	5	Congress	Examines tax credit incentives for EDI costs
BILLING	6	Industry	Adopts standardized billing content
IDENTIFIERS	7	WEDI	Determines system for unique identifier
CONFIDENTIALITY	8	Congress	Enacts federal confidentiality legislation
COB	9	Industry	Develop process/guidelines for COB
DEMONSTRATIONS	12	WEDI/IND*	Stimulate/publicize demonstration projects
ANALYSIS	13	WEDI/IND*	Conduct analysis of EDI costs
IMPLEMENTATION	2	Industry	95% Cat. I partners implement EDI/standards
COB	9	Industry	Creates crossover format for COB
CLEARINGHOUSES	11	Industry	Creates clearinghouse accreditation program
IDENTIFIERS	7	Industry	Adopts unique identifiers
INCENTIVES	4	WEDI/IND*	Create incentives for EDI use
IMPLEMENTATION**	2	Industry	85% Cat. II partners implement EDI/standards
IMPLEMENTATION	3	WEDI	Progress reports to DHHS Secretary



[A] Recommendations Number in WEDI Report
[B] Responsibility For Task
* WEDI/IND: Initiated by WEDI, implemented by the Health Care Industry (Public and Private Sectors)
** By Fourth Quarter 1996

Attachment 2

WEDI STEERING COMMITTEE LISTING- 1993

Blue Cross and Blue Shield Association, Co-Chair

The Travelers Insurance Company, Co-Chair

Self-Insurance Instiute of America

Aetna Health Plans

American Hospital Association

United Healthcare

Galen Health Care, Inc.

Blue Cross and Blue Shield of Virginia

American Nurses Association

American Dental Association

American Medical Association

Mutual of Omaha

Drug Benefit Management Systems, Inc.

American Clinical Laboratory Association

Medical Group Management Association

Aetna Life & Casualty

Health Insurance Association of America

National Committee to Preserve Social Security and Medicare

National Association for Home Care

American Association of Retired Persons

Blue Cross of California

Medical Care Administration, Department of Income Maintenance, State of Connecticut

American Managed Care and Review Association

Bureau of Program Operations, Health Care Financing Administration

American Health Information Management Association

American Health Care Association

Attachment 3

Co-Chair
Joseph T. Brophy
President
The Travelers Companies

WEDi
Workgroup for Electronic Data Interchange

Co-Chair
Bernard R. Tresnowski
President
Blue Cross and Blue Shield Association

March 30, 1993

First Lady Hillary Rodham Clinton
Health Care Reform Task Force
The White House - West Wing
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Mrs. Rodham Clinton:

We commend your hard work on health care reform.

Although our current health care system is complex, government and the private sector can together reform health care by reducing paperwork and lowering administrative costs. These are the primary goals of the Workgroup for Electronic Data Interchange (WEDI).

WEDI is a voluntary, public-private task force created in 1991 to streamline health care administration through standardized electronic communications. WEDI envisions a health care industry transacting all of its business electronically, using one set of electronic standards and interconnecting networks. Our comprehensive 1992 report, which we are enclosing, outlines how we believe that vision can be achieved.

This year WEDI has expanded its membership to include 22 national organizations, representing payers, providers, consumers, federal and state health care governmental agencies, and business. We're working together to resolve issues relating to implementing electronic data interchange (EDI). We expect to issue our 1993 report this summer and we hope you will find the attached preliminary recommendations useful in your deliberations.

WEDI has achieved a major and historic consensus in health care: agreement by all parties to use one set of electronic standards to transmit health care information . That standard is the American National Standards Institute's (ANSI) X12 standard. Industry-wide use of ANSI X12 is the key to implementing EDI and reducing administrative costs. It is central to WEDI's plan, and we urge you to support federal legislation mandating the use of approved ANSI X12 standards for health care transactions.

The WEDI recommendations are consistent with President Clinton's "Technology for America's Economic Growth, A New Direction to Build Economic Strength" (February 22, 1993) by encouraging standardized automation in the health care industry.

We would appreciate the opportunity to meet with you or your representative to discuss the WEDI activities in greater detail. Please call the WEDI Steering Committee Co-chairmen, Joseph T. Brophy at Travelers (203-277-3122) or Bernard R. Tresnowski at Blue Cross and Blue Shield Association (312-440-6010). Thank you for your interest.

Sincerely,

Bernard R. Tresnowski

Joseph T. Brophy
The Travelers

Bernard R. Tresnowski
Blue Cross and Blue Shield Association

cc: The Honorable Donna Shalala
Ira Magaziner

Preliminary Report

The Workgroup for Electronic Data Interchange

March 1993

Legislate ANSI X12 Standards for Health Care

- WEDI recommends the use of ANSI X12 standards for all health care EDI transactions. We further recommend federal legislation mandating the use of approved ANSI X12 standards to expedite EDI implementation within the health care industry.

Time-frame for Implementing the ANSI X12 Standards

- Given ANSI's rapid development of the core health care transactions (eligibility, enrollment, claims submission, and claim payment), we believe the implementation schedule outlined in the WEDI report can be advanced. Successful implementation of ANSI X12 standards will require that implementation guides be developed within a reasonable period of time following approval of the standard.

- We recommend federal legislation mandating the implementation of the ANSI X12 standards according to these revised timeframes:

  - Major public and private payers, hospitals, major employers and self insured plans, and clinics and group practices of 20 or more professionals (Category I) must implement approved ANSI X12 standards one year from passage of the federal legislation or 4th quarter of 1994, whichever is earlier.

  - All remaining health care payers, providers, employers and self insured plans and pharmacies (Category II) must implement approved ANSI X12 standards two years from passage of federal legislation or 4th quarter 1995, whichever is earlier.

  - The mandate will provide the Secretary with discretion in the transitional implementation time frames. For example, in the case of pharmacy electronic standards, we recognize the NCPDP standards are already interactive and may be used until the interactive ANSI X12 standards are developed and approved. At such time, NCPDP will transition to the ANSI X12 interactive standards.

Other Implementation Issues

- Health Card Technology

  - In the short term, if health cards are used, we recommend that the card adhere to ANSI X12 standards. We further recommend that the card contain only identification information, however, the technology should be flexible for other potential uses.

  - In the future, we anticipate that medical and administrative systems will not require a card.

- Unique Identifiers

  - PATIENT IDENTIFIER. A number of alternatives are being examined, including the use of the Social Security Number.

  - PAYER IDENTIFIER. We recommend that the National Association of Insurance Commissioners Co-Code be used as the payer identifier. The Co-Code should be expanded to include all HMOs, TPAs, and other health care entities.

  - PROVIDER IDENTIFIER. Our tentative recommendation is to charge a broadly based umbrella organization, working with professional associations and others, to maintain a unique provider identification system.

  - EMPLOYER IDENTIFIER. A number of alternatives are being considered , including the tax identification number.

- Implementation Guides and Data Content

  - Extensive EDI education at the administrative/planning level and the technical level will be required.

  - Establish an industry group to coordinate the activities of professional associations and others who will be developing implementation guides and standardized data content.

  - The National Uniform Billing Committee and the Uniform Claim Form Task Force should be consulted in standardizing the codes.

- Confidentiality, Security, and Fraud

  - WEDI is drafting model federal legislation designed to preserve confidentiality and privacy rights in the electronic transmission and handling of health care information, and to preempt state laws in that regard. It expands upon the precepts contained in the 50-page White Paper on Confidentiality in the WEDI Report.

  - Electronic environments can improve our ability to detect health care fraud. The final report will include recommendations for audit capabilities in an electronic environment, and the attendant savings accrued from improved fraud detection.

- Network Architecture

  - We recommend that all health care providers submit insurance claims or managed care data, on behalf of their patients, to all industry payers.

  - We recommend a 15-day payment ceiling for electronically submitted claims not requiring further investigation. During the transition period, we recommend a 30-day payment floor for paper claims.

  - All industry payers and clearinghouses must promote an open access interconnectivity of EDI networks.

  - Establish clearinghouse accreditation programs that adhere to WEDI guidelines.

Financial Implications

- The application of EDI has tremendous potential for improving the health care system through the reduction of administrative costs and improvements in the quality of health care.

- Although WEDI reported preliminary annual savings of $4 to 10 billion, we believe there is a potential for much greater savings.

- We recommend the following positive financing incentives to encourage speedier EDI implementation by Category II participants.

  - Category II payer financing in the form of small business loans for EDI development.

  - Tax incentives to facilitate initial investment by small and rural providers and small employers in acquiring EDI technology.

  - Encouragement of physician staff education on the value of EDI through job training credits to the physician's office or practice.

  - Small health care software vendor financing in the form of small business loans and increased education through job training credits.

EDI: The Infrastructure for Improved Patient Care and Health Care Policy Decisions

- EDI will evolve to include other health care data such as clinical data. Other industry groups are looking at computerizing the patient medical record. In time, all health care financing and delivery information will be readily available, leading to better health care decision-making and overall quality of care.

- The WEDI recommendations are consistent with President Clinton's "Technology for America's Economic Growth, A New Direction to Build Economic Strength" (February 22, 1993) by encouraging standardized automation in the health care industry.

Chairman STARK. Thank you all.

Do any of you have an objection if we were to use a unique number in whatever system evolves of having that be the Social Security number? Does that offend any of you?

Mr. BERND. No.

Dr. CLOWE. No.

Ms. FOX. No.

Mr. NEUSCHLER. No.

Chairman STARK. I guess, Dr. Clowe, the AMA has some concerns with mandating a uniform system.

Dr. CLOWE. That is a concern of the AMA, sir.

Chairman STARK. You don't have any concern with our mandating private insurers and self-insured firms to use a single claim. You want us to mandate them but not the docs. Is that how I read your testimony?

Dr. CLOWE. No. Actually, the future probably would be mandation, but we believe right now this system should go forth slowly.

Chairman STARK. It has been doing that.

Dr. CLOWE. Well, we have found that physicians in groups of over eight physicians——

Chairman STARK. Use a high number, 60 percent or something.

Dr. CLOWE. Right, 60 to 70 percent. Those physicians and rural physicians.

Chairman STARK. And younger physicians.

Dr. CLOWE. Well, younger physicians are also signing up for it, far ahead of the older physicians. But the rural physicians we are somewhat concerned about, as they are concerned, because they don't want to spend the money to put this apparatus in place.

Chairman STARK. Well, they are higher, though, nonmetropolitan are 47 percent, metropolitan of a million and over only 32 percent, so it looks like your rural guys are using it more than the big-town fellows.

Dr. CLOWE. But not the solo practitioners in rural communities.

Chairman STARK. OK.

Let me ask you this just as a practical matter. You are a family practitioner. Are you solo or in a group?

Dr. CLOWE. Solo family practitioner.

Chairman STARK. OK. For you, it should be the most difficult.

Dr. CLOWE. Very.

Chairman STARK. You have the widest array of procedures.

Dr. CLOWE. Right.

Chairman STARK. Widest fix of patients and probably the highest number of personnel per professional provider?

Dr. CLOWE. That is correct.

Chairman STARK. But you use a credit card?

Dr. CLOWE. Yes.

Chairman STARK. And you know that if you want to call up and order—if you are like me and you get your back-to-school clothes from Land's End, you can call up and give them your credit card over the phone, and if you do it too much the bank will call and make sure somebody else doesn't have your credit card.

At some point, how difficult is it going to be if the other side, the patient and the insurance companies, provide a standardized form?

You are going to have to buy a card reader. That can't cost $50. The worst you would have to do is use one of those card readers and a key pad.

Dr. CLOWE. Right.

Chairman STARK. But I will bet you have a computer in your office.

Dr. CLOWE. Yes.

Chairman STARK. I am not suggesting that we say something that you don't like, but if everybody else is in the game to pick up this 30 to 50 percent of the docs or the 20 percent of the hospitals or the pharmacists or whoever, at some point aren't we just going to have to say everybody has to do it and then make whatever provision for religious objections to computers or a lack of rural electrification or whatever the heck we have to do?

I mean, arguably, we are going to have to let somebody still do it with a pencil. But I just get the sense that—and that is where I hope we could get you to help us—at some point, we are going to have to say, this is the day we all do it.

Dr. CLOWE. Well, Mr. Chairman——

Chairman STARK. It is like putting numbers on the bottom of the checks. I will bet you are old enough to remember when you didn't have the electronic numbers on the bottom of your checks, and, finally, the bank said you have to do it.

Dr. CLOWE. That is correct. But if you will look at the statistics, in the last year it has been a marked increase in the number of physicians who have gone to electronic billing and claims, and we are hoping that we won't antagonize the thousands of rural physicians out in the communities who don't want to do it.

Chairman STARK. I do, too, or the Senate won't support us. I understand that.

What if we said 3 years that the hammer is going to drop in 1997 and that is everybody.

People say, I don't want to do it. And I guess I am just saying, at some point, if the system is going to work, somebody has to mandate or it is OK, you don't want to get paid electronically.

The incentive I look at is, you submit your bill electronically, you get it deposited right to your account electronically, you submit a handwritten bill in the mail, you take your chances with the post office, get the check back in the mail, and I bet I could entice a lot of your rural companions that 2 week less float would be pretty enticing.

I don't mean that we won't pay people or make it helpful. But, I would ask the rest of the witnesses at the table what is enough? 80 percent? 90 percent? At some point, we just have to say this will be the payment standard. And we can't force them. If you don't want to collect—we can with Government payment, but we can't force insurance companies to do it.

Dr. CLOWE. You must understand, Mr. Chairman, physicians are independent individuals.

Chairman STARK. Oh, I have learned that.

Dr. CLOWE. And we sometimes in leadership roles have difficulty convincing them that this must be done.

Now, the pressures of electronic delivery is increasing all the time. More and more offices, as you see in the past year, are taking

this up. But I predict in 3 years the voluntary system will work, that the majority of physicians in this country within 3 years will have this system, but——

Chairman STARK. You think at that point then we could say there will be a standardized system and anybody who doesn't do that will have to submit their claims by hand and suffer a longer waiting period and so forth?

Dr. CLOWE. That is right.

Chairman STARK. OK.

Mrs. Johnson.

Mrs. JOHNSON. I have three quick questions.

To follow up on the Chairman's line of questioning, Dr. Clowe, wouldn't it make a big difference if the Government provided the hardware or if somebody provided the software, perhaps at a discount to small offices?

Dr. CLOWE. Yes.

Mrs. JOHNSON. What I am hearing from my district is that small offices can't afford to do this once and then in 6 months do this again and in 6 months do this again.

Chairman STARK. Would the gentlelady yield?

Mrs. JOHNSON. Yes.

Chairman STARK. I would go a step further. I think the software ought to be state-of-the-art software that is provided to the whole country. I think the software ought to be given to everybody, and somebody should be responsible updating it so that we aren't encouraging Ross Perot to get another $15 billion contract.

Mrs. JOHNSON. But might we send out memorandums on billing issues? My sense has been from the little guys out there, particularly in the more rural areas of my district, that that is the concern. And, if we manage that issue, it is a lot like the problem of approving a law and not passing the regulations. They are very much afraid of being required to do something and not being able to buy something on the market that will do it right.

Dr. CLOWE. That is correct. I agree.

Mrs. JOHNSON. Mr. Bernd, you mentioned that you were very concerned that the simplification effort would go forward but lose sight of the future evolution of the delivery system. Can you give us some examples of how administrative simplification reforms that are currently being contemplated might have an adverse impact in the future.

Mr. BERND. I don't think I exactly meant that. What I said is, we can't simply focus on administrative costs, I think we also need to look at reforming the health care delivery system. I think that is where we can have larger savings and, hopefully, better access to care, so I think they go hand in hand. I just don't want to lose the focus. We believe very strongly in reforming the health care delivery system.

Mrs. JOHNSON. I thought your enumeration of barriers, split billing, definition of outpatient/inpatient, that is very helpful. And I think the extent to which you identify individual barriers this committee could probably be helpful in reiterating that this is the kind of thing that needs to be addressed not by us at this point but by others so that there is greater pressure to really deal with the

kinds of impediments that are a part of your daily operating existence.

Outside of the need for this committee to lead the way perhaps in legislation that would address the confidentiality concerns, is there other legislation that is needed to enable this effort to go forward or can you do it mostly on your own and with the WEDI assistance? Anyone who cares to respond to that?

What I am hearing from you is the process is going well. We can do it. We are a little afraid about the technology and some of those things. But the only legislative action I see needed at this point is the confidentiality issue.

Ms. FOX. Yes, we agree. Yes, we think that we can do it without Federal legislation. And if we don't achieve those goals, then we think legislation is appropriate at that point, but we think we can do it without Federal legislation. In fact, we are making great strides.

Mrs. JOHNSON. I guess confidentiality and uniform standards.

Chairman STARK. Would the gentlelady yield at that point?

Mrs. JOHNSON. Yes, I will yield.

Chairman STARK. Assuming you don't want legislation to mandate, somebody has got to shoot the gun to start the race. We can't just all stand around looking at each other, say you go first, or we will have the Alphonse and Gaston sort of thing going.

Would it be sufficient if Medicare and Medicaid say this is the system we are going to use, and, therefore, everybody must use this protocol? Would that be enough of a standard bearer or guidepost so that the other providers would fall into place so you don't have to have a law? You just say, this is how we are going to pay for about the 30 or 40 percent that the government now pays and then allow other people, because it would be convenient to follow that protocol—would that—or would you rather have us legislate the whole megillah?

Mr. BERND. If you look at the history of UB–82 and 92 it didn't work very well. We get requests for entire medical records to go along with the UB–82. It just proliferates.

Chairman STARK. That sort of would be my feeling, that somebody has to say we are going to do it by this time or we are going to have another system that is going to be one shoe off and one shoe on.

Dr. CLOWE. I would say that we are very fortunate, the AMA, to be part of WEDI, and we were called in, as have other individuals been called in, so the spirit of cooperation is tremendous on this, and I think it will go forward. It is just convincing the individuals who are involved that they should go along with the program.

Chairman STARK. But don't you agree that, at some point, somebody has to say this is it? I mean, we have to vote or do something.

Dr. CLOWE. Mr. Chairman, that is a government point of view.

Chairman STARK. Or even your group—even WEDI has to say, here is the one protocol. We agree by three to four or we don't agree. I don't care who makes that determination, but at some point everybody has to agree that there is a system.

To my way of thinking, it is not tremendously onerous, let's say, if WEDI does it first somebody has to at least drop the gavel and say, OK, that is it.

Dr. CLOWE. If in 3 years, Mr. Chairman, you find that the voluntary effort has really worked, which we are very hopeful that it will with the marked increase this year, that would not be necessary because it would just flow that the rest of the groups would join in. In other words, you would have your problem solved without mandation.

Mrs. JOHNSON. Mr. Chairman, I find it very hard to understand Mr. Bernd's response to your comment.

If in 3 years WEDI has completed its work and we have put in law the confidentiality issue and the uniform standards thing is moving along very well that you will have done it in some of the billing areas. But we will be moving along in the clinical data areas, and we simply mandate that is the way the government pays its bills. And if you participate in government programs it is the only way you can get paid. I fail to see why we need an actual law that implements it. I don't see how you could survive out there if you don't join our system.

Chairman STARK. We would have to have the law to say that is how the government pays it. You could do that. Then if everybody else joined in, swell. If they didn't, we would be back here.

It is not an issue of major concern to me. It just seems to me that we have done it in other areas. Usually we do it in engineering. We have Federal standards for nuts and bolts, water quality. Sometimes those are a problem, but somebody has to lead the orchestra.

Mrs. JOHNSON. If we go ahead and do it in the government and we provide the software and things like that—I think what Dr. Clowe is responding to is that sort of anxiety out there in the public that if we put it in the law we will put more perhaps in the law than we ought to so there is that sense of endangerment.

Chairman STARK. We have great ability to screw things up. I would be the first one to stipulate to that.

But in this case, if they design the system and then we just say, OK, that is what it will be. At some point all I am concerned about is that we get going.

Mrs. JOHNSON. Thank you, Mr. Chairman.

Chairman STARK. Thank you.

One further request of Mr. Bernd. Is this your chart? Do you operate in Maryland?

Mr. BERND. No, sir.

Chairman STARK. OK. Would you try this chart for me as if you had a single payer system or Maryland's all-payer system without copays?

Mr. BERND. Sitting here at this table without any help, no, I couldn't do that.

Chairman STARK. No, I am just saying for the heck of it on your train ride home.

Mr. BERND. I can do——

Chairman STARK. Would these process steps shorten dramatically, basically, if you used DRG's or whatever single billing system you want to pick, and——

Well, let's say, for more reality, that the copays were limited like medigap so that there is 1 of 10 systems. And it would either have to be 1 of 10 or none. How many of these boxes would fall off?

Arguably, you could make the case that all your collection procedures would drop if, in fact, there was universal coverage. That would make some sense. I would just be curious.

Mr. BERND. We will do that and send it back to you.

Chairman STARK. Thank you.

[The information follows:]

American Hospital Association

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11 June 1993

Janice Mays
Chief Counsel and Staff Director
Committee on Ways and Means
1102 Longworth HOB
Washington, D.C. 20515

Dear Janice:

At the health subcommitte hearing on administrative cost simplification held on 25 May 1993, Rep. Stark requested that the AHA witness--Mr. David Bernd of Sentara Health Systems in Norfolk, Virginia--rework the chart he submitted with his testimony. When I returned the corrected transcript of the hearing on 3 June, I asked that Mr. Bernd be granted an additional week so his staff could respond adequately.

I am enclosing two reworked versions of the chart Mr. Bernd's staff prepared. The first shows patient billing under a DRG system. Assuming that the DRG rate were the rate for all payers, this chart could show payment processes for a single-payer system.

The second chart shows patient billing under a capitated system. The AHA vision for health care reform includes capitated payment to networks of providers.

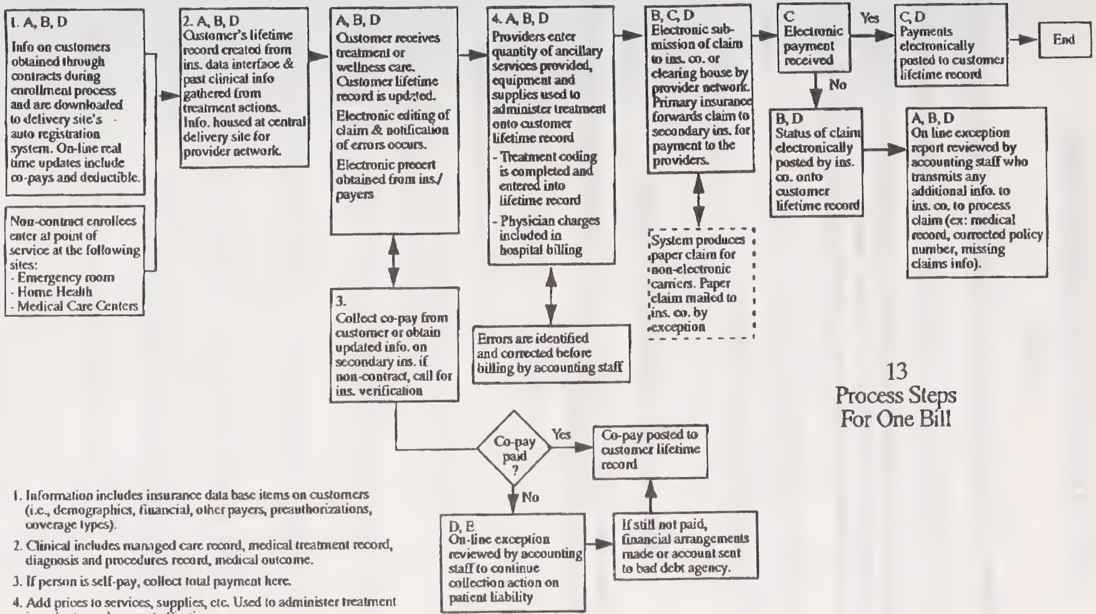
Thank you for your attention to this matter.

Sincerely,

Patti Goldman

Patti Goldman
Senior Associate Director
Congressional and Executive Branch Relations

Patient Billing Within the DRG System



13
Process Steps
For One Bill

1. Information includes insurance data base items on customers (i.e., demographics, financial, other payers, preauthorizations, coverage types).
2. Clinical includes managed care record, medical treatment record, diagnosis and procedures record, medical outcome.
3. If person is self-pay, collect total payment here.
4. Add prices to services, supplies, etc. Used to administer treatment in order to analyze cost effectiveness.

* Note: Refer to A, B, C, D Technology Key (attached)
Central delivery site is any site where care is delivered within Sentara.

KEY TO TECHNOLOGY CHANGES REQUIRED

DRG

A. Electronic editing of account from beginning of wellness care or treatment to the end.

B. Provider computer system interfaced with payers and clearing houses. On-line real time.

C. Automated payment posting system. Agreement by all parties in the healthcare industry to use a standard set of information to facilitate both the receivers and senders of remittances in automating the posting of payments to the providers internal system.

D. P.C.'s and decision tree software for all employees in process.

E. Automated collection system for patient balances.

ADVANTAGES OF THE DRG SYSTEM

Focus is removed from individual prices for total medical care and placed on total process efficiency. This reduces the cost of healthcare.

ASSUMPTIONS FOR THE IDEAL PROCESS

DRG

1. Replaces manual processes with total electronic process, as a result reduced administrative cost.

2. Patient registered one time for total care provided by network. Example: patient enters at physician office and is registered at office. Registration information flows throughout the system.

3. Perform concurrent medical record coding.

4. Provider network is interfaced electronically with insurance companies.

5. Automatic verification of insurance benefits provides accurate knowledge of deductible and coinsurance and reduces payment turn around time.

6. Customer lifetime records provide cumulative patient medical history which can be used to enhance quality of care.

7. DRG effects amount of money paid, not process by which payment is received.

8. Pay by DRG for both outpatient and inpatient services.

9. All payers accept same data set.

10. Maintain same data for all payers (storage of medical records, signed forms, special forms, i.e. all administrative processes.)

11. One form for all types of billing. The universal form would be standardized for all providers of healthcare.

12. Standard definition of type of service for all payers/providers. Example: Observation vs short stay.

13. One nationally defined DRG data set that is not variable by payer.

14. Any secondary carrier covers whole deductible (i.e. copay) no write off to contractual if primary DRG is equal or greater than secondary insurance would have paid.

15. Basic coverage will have low deductible or no deductible.

16. Follow up responsibility is shared by health care systems and insurance companies through use of interfaced computer systems that allow claim status to flow from one system to another.

17. Define timely payment. There should be a set number of days to pay the claim with penalties imposed for non-compliance that has been agreed upon by all parties.

18. Audits done on retrospect instead of prospect.

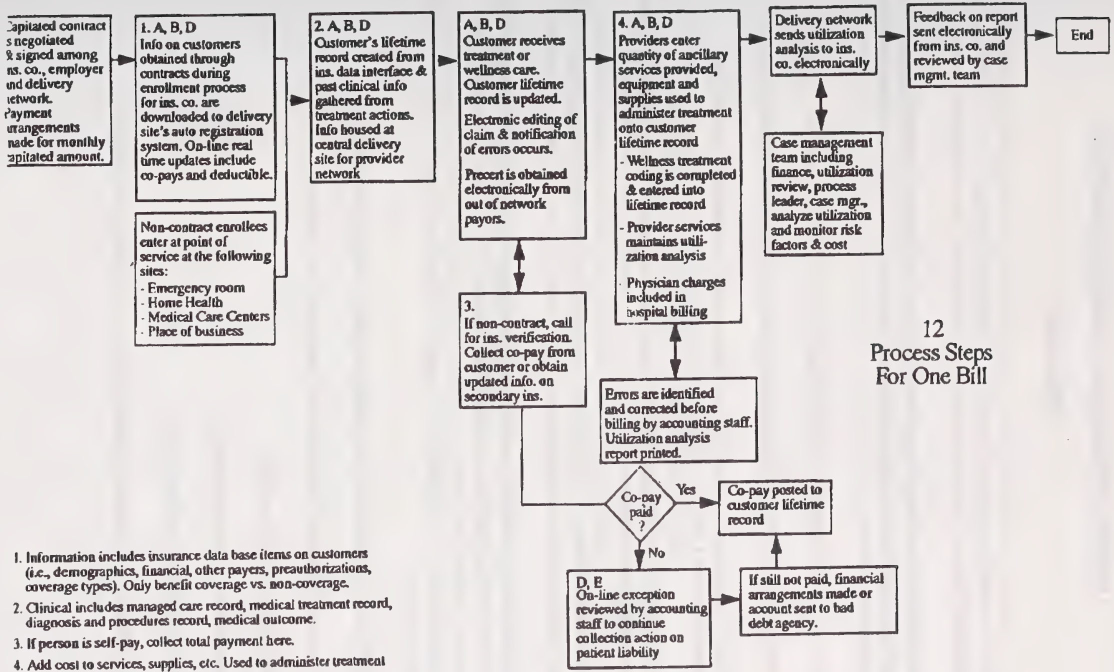
19. Standardize what auditing procedures are followed and what is audited by case management for medical conditions.

20. Coverage is simple and standard. Clearly define the benefits covered.

21. Patient data base downloaded electronically as soon as contract signed.

22. Clearing houses will be responsible for forwarding all claims to insurance companies.

Patient Billing Within the Capitated System



1. Information includes insurance data base items on customers (i.e., demographics, financial, other payers, preauthorizations, coverage types). Only benefit coverage vs. non-coverage.
2. Clinical includes managed care record, medical treatment record, diagnosis and procedures record, medical outcome.
3. If person is self-pay, collect total payment here.
4. Add cost to services, supplies, etc. Used to administer treatment in order to analyze cost effectiveness.

* Note: Refer to A, B, C, D Technology Key (attached)
Central delivery site is any site where care
is delivered within Sentara.

ASSUMPTIONS OF IDEAL PROCESS CHANGES

CAPITATED

1. Replaced manual processes with total electronic process, as a result reduced administrative cost.

2. Patient registered one time for total care provided by network. Example: patient enters at physician office and is registered at office. Registration information flows throughout the system.

3. Perform concurrent medical record coding.

4. Provider network is interfaced electronically with insurance companies.

5. Automatic verification of benefits provides accurate knowledge of deductible and coinsurance and reduces payment turn around time.

6. Customer lifetime records provides cumulative patient medical history which can be used to enhance quality of care.

7. Physicians are included in the capitation payments and contracts are negotiated between the healthcare system and physicians.

8. Standard reporting between providers and contractors on group level for ancillary and equipment and other services provided during care.

9. Flat amount paid for each patient no matter what service is provided but for any care needed or no care.

10. Eliminate need for electronic payments per claim, just per contract.

11. One lump sum payment from insurance companies per contract.

12. Rate based on cost of care risk.

13. Emphasis shifts to cost accounting.

14. Emphasis will be on wellness care.

15. Standard format for electronic transmission of data between all parties.

KEY TO TECHNOLOGY CHANGES REQUIRED

CAPITATED

A. Electronic editing of account from beginning of wellness care or treatment to end.

B. Provider computer system interfaced with payers and clearing houses. On-line real time.

C. Automated payment posting system. Agreement by all parties in the healthcare industry to use a standard set of information to facilitate both the receivers and senders of remittances in automating the posting of payments to the providers internal system.

D. P.C.'s and decision tree software for all employees in process.

E. Automated collection system for patient balances.

ADVANTAGES OF THE CAPITATED SYSTEM

1. Focus is removed from individual prices for total medical care and placed on total process efficiency. As a result this reduces the cost of healthcare.

2. Emphasis on wellness and preventive medicine will raise overall health of population.

3. Physicians are included in the capitation payments and contracts are negotiated between the healthcare system and physicians. This promotes efficiency of treatment as well as quality as physicians share in risks and rewards of the entire provider network.

Chairman STARK. I want to thank the panel. This is an area in which I hope we are going to make some accomplishments. I hope we can help you get to the goal that we all want to achieve here, and we appreciate the participation of you and your organizations in helping us achieve that goal.

Our last group of witnesses will include Dr. Ralph Korpman, who is the president and chairman of the Health Data Sciences Corp., representing the Health Industry Manufacturers Association. Mr. Richard Clarke, the president of the Health Care Financial Management Association. Mr. Jim Houtz, chairman of CyData Systems, Scottsdale, Ariz., representing the Association for Electronic Health Care Transactions. Ms. Linda Ryan, director of the New York Health Care Information Clearinghouse Program, and she is representing the New York State Department of Health. Mr. Jeffrey Spears is representing the IBAX Healthcare Systems, and Dr. Frank Frost, president of FF255, Inc., in Omaha, Nebr., representing HealthCare USA.

We would remind you that your prepared testimony will appear in the record, and you may enlighten us or summarize your testimony in any way you are comfortable.

Chairman STARK. Dr. Korpman, would you like to lead off?

STATEMENT OF RALPH A. KORPMAN, M.D., MEMBER, HEALTH INDUSTRY MANUFACTURING ASSOCIATION, AND PRESIDENT AND CHAIRMAN, HEALTH DATA SCIENCES CORP., SAN BERNARDINO, CALIF.

Dr. KORPMAN. Thank you, Mr. Chairman and committee members.

I testified at this hearing last year, and I remain struck this year by what I was struck by last year, which was you would think, listening to this hearing, that health care was the business of caring for bills and insurance companies and doctors. And, last I looked, health care was in the business of caring for patients.

And, lest we forget, patients are not inpatients. They are not outpatients. They are not managed care patients. They are not all-payer patients. They are patients. And the substance of delivering health care has to do with the management of information.

Now we talk about administrative simplification, which is an area that is near and dear to the heart of HIMA and its members. The Health Industry Manufacturers Association represents 300 manufacturers of medical devices and health care information systems. We deliver most of the systems technology to physicians and hospitals that are trying to do the tasks that have been talked about this morning.

When we look at information and what is involved in health care delivery and administration there are three components.

First, there is financial and billing information; it is important that we simplify that. Everyone so far has talked about that and other people on this panel will continue to do so, so I am not going to spend any more time on it. Second, there is administrative information as a byproduct of the operation of the core system.

However, most of the information that is used and most of the money that is spent on administrative work is spent on clinical administrative work. A third of a physician's time and half of a

nurse's time—everybody else in the health care delivery system falls somewhere in between—is spent doing paperwork, not to send the bill but to record care, see if it is up to standards, try to protect oneself from torts and try to make sure the right things happen to the right patient at the right time and document that they did.

If we really want to talk about saving money with administrative simplification, regardless of the health care reform system that is picked, clinical administrative simplification is where we need to look. There are, basically, three immediate benefits that eventuate from such administrative simplification.

The first benefits are direct operational savings. One can certainly save some money by simplifying the insurance system, but we may soon have a health care payment system that has no insurance paperwork and then what has been accomplished by simplifying a dinosaur?

Mrs. Johnson brought up some of the other aspects of some of these changes as one raises here and lowers there, but there appear to be significant available savings regardless of the reform, if any, that is chosen. Arthur D. Little did a fairly extensive study of this recently and concluded that whatever you could save on the administrative side you could save six times more if you dealt with the clinical administrative paperwork.

Now, people bandy all kinds of cost savings numbers around for administrative simplification, but the relative numbers we expect are probably accurate. If one does reduce the administrative clinical work by using automated electronic capture of clinical information and automatic coordination and scheduling of patient—care as opposed to the random way it happens now—this does three things.

First of all, there is a direct effect on the cost of providing care. There was a very interesting article that came out in the Journal of the American Medical Association in January where they looked at a fairly limited case—but a typical one—and concluded that, with rudimentary clinical administrative simplification, $900 per Medicare admission could be saved—real hard-cost savings. There are a lot of Medicare admissions, and you multiply those by $900, and that is a lot of money. And similar people find similar savings when they look.

Second, there are significant quality issues in terms of the quality of care with the paper system, and there are expensive, duplicative and repetitive administrative systems put in place to try to help that quality get better. What happens is practitioners find themselves filling out more and more forms to do less and less good. Then these forms go to the PRO or wherever they end up, but to little avail.

Lastly, as has been brought up by the committee more than once today, we take all this data, put it in a giant pot, and then, after we have carefully written it down we throw it away in medical records. If you really want to have intelligent health care reform and you really want to improve the quality of health care, there isn't enough data to do either task. Again, the reason we don't have the data is because it is all written down in an inaccessible form instead of putting it in a form where it can be used to do some good.

And I find it interesting AHCPR is working on a giant several thousand patient prostate study to discover whether it is better to take prostates out or to treat them with Proscar or to do this, that, or the other thing. The vexing issue is that Medicare is paying every year for a million prostate exams which are carefully being recorded on paper, and all that data is effectively being "thrown away" and is unavailable for analysis. If one really wants to know how to take care of prostates or breast cancer, requiring comprehensive uniform clinical data is what is needed. If one wishes to do payment based utilization review, one still needs the same data.

How can the government help? There has been some discussion about this already today.

There is a broadly disseminated fallacy in this area. One is that this can't possibly be done now. Give us 10 years. Give us 15 years. Maybe we can do something then. As the deliverers of these systems, we say that is not true. This kind of administrative simplification can be done now. We can give you examples of forward-looking health care organizations: the Graduate Health Care System in Philadelphia or New York City Health and Hospitals Corp., who are moving forward with a complete electronic clinical administrative simplification system now. It takes will, and it takes action but it can be done.

What the government can do is to layer standards on the clinical administrative simplification process—something that I think—even though some people up here wish it wouldn't happen, and we don't think it can be done voluntarily. Because, if you are a patient who lives in New York and you get ill in Topeka you want your record to come with you, then we need a layer of standards.

Now, people debate there is no perfect standard, and that is true. However, an imperfect standard would be an improvement, and you could further develop it over time. There has been a lot of talk about mandating a single system. You cannot mandate a state-of-the-art system. As soon as you mandate it, it will be non-state-of-the-art. All you need to do is look at the computer technology in use in military equipment and you will discover how rapidly it falls off state-of-the-art once it is mandated.

What can be mandated is standards which need to be picked up by everybody who is delivering. The state-of-the-art will jump ahead as the commercial marketplace pushes forward to comply with such standards.

We at HIMA believe that this are of administrative simplification is compellingly important. We believe there are real savings, especially in clinical administrative simplification regardless of the health care reform system in place. We believe such savings can be effected now, and we are happy to be of assistance in any way we can.

Thank you.

Chairman STARK. Thank you.

[The prepared statement follows:]

TESTIMONY OF RALPH A. KORPMAN, M.D.
HEALTH INDUSTRY MANUFACTURERS ASSOCIATION

Good afternoon. My name is Ralph Korpman and I am the President and Chairman of Health Data Sciences Corporation of San Bernardino, California. Health Data Sciences is a small, rapidly growing company of 180 employees that produces an innovative new generation of bedside integrated health care information systems. I am pleased to be here today to testify on behalf of the Health Industry Manufacturers Association (HIMA) concerning administrative simplification. The Association enthusiastically supports efforts to simplify and automate the administrative aspects of health care delivery and financing. HIMA is a national trade association of more than 300 members representing manufacturers of medical devices, diagnostic products, and health care information systems (HIS). The HIS manufacturers provide systems and services for financial processing, management functions, and clinical care. It is through the HIS companies that HIMA is able to share with the Subcommittee the experience and insight gained from developing, integrating, and supporting computer software for hospitals and physician offices across the country.

The administrative simplification reforms being considered today primarily concern methods for improved use of fiscal and clinical data. This underscores the critical fact that *health care is an information industry* -- most health care providers spend the majority of their time creating or using information. Significantly, only a small percentage is then abstracted and submitted to payers, reviewers, and other agencies. The rest is maintained on paper at high cost and is not readily available for review or analysis. Although it is an information industry, health care lags behind almost every other information industry in its level of expenditures on information support, and in its use of automation to improve efficiency, effectiveness, and quality.

We look forward to continuing to participate in the development of broad scale administrative simplification methods for the health care systems of the future. Whatever path is chosen in this reform process for providers, payers, and patients, it is the HIS industry who will be tasked with making it work. The following statement describes the cost savings and quality enhancement of both financial and clinical HIS applications, as well as recommendations for further improvement in HIS use. HIMA strongly believes that appropriate systems can lower current administrative costs, improve data quality, and can improve the quality of patient care. Ultimately, they will provide the necessary data for health care reform and assessment of the health care system. While HIMA's HIS companies develop both financial and clinical HIS applications, I will focus my comments today on the clinical applications, because other witnesses on the panel will address the financial applications in detail.

SYSTEM CAPABILITIES

Financial Applications

For two decades HIS manufacturers have developed and installed data systems for electronic processing of hospital and physician claims for both public and private payers. Use of such financial systems allows rapid and more accurate preparation and submission of health care claims data for the provider. Moreover, payers also save through the streamlined screening and payment process accomplished in less time with fewer personnel than required for paper claims. Medicare cost reporting has also been simplified through the application of HIS software to assist in the year-end settlement of facility claims.

Additionally, technology is already in place to speed the actual payment process through the electronic funds transfers directly to financial institutions. The Medicare program is leading the way in this area and other payers are expected to join the process quickly.

Several HIMA manufacturers have incorporated on-line verification of eligibility and benefits directly into their health care system-wide information systems. The incorporation of such checking as a seamless part of the hospital's total information system, rather than as a separate stand-alone eligibility verification step, further serves to eliminate administrative overhead while automatically providing the necessary verification of a participant's insured status.

Most importantly, as savings are achieved, the quality of the data actually improves. In practice, the elimination of paper documentation and control systems improve data quality by amounts as high as 40%. The increase in data quality is experienced for all forms of data processing -- financial, clinical, and administrative.

Clinical Applications

Financial processing already involves provider time to some extent. The administrative portion of clinical care requires an even greater investment of time. About one-third of a physician's time and almost one-half of a nurse's time is spent doing clerical/administrative work; time that could be far more effectively invested in patient care. There is a belief among some that systems to provide clinical management improvements are years away. In fact, the kinds of applications necessary to improve clinical efficiency and the quality of our health care system exist now and are in operation in selected areas. For instance:

- The William Beaumont Hospital Corporation in suburban Detroit installed an integrated, patient-centered system throughout its two facilities of almost 1,200 beds. After installation of the HIS system, the facility experienced a significant increase in both occupancy and patient severity. As a general rule, when occupancy or patient severity increase, there is a concomitant increase in staff. Because personnel costs represent a major portion of a hospital's total operating costs, each staff increase is highly significant. At Beaumont, however, even with both factors increasing, there was actually a *decrease in staff.* Moreover, there was a simultaneous increase in patient care quality, with 100% compliance scores on both Joint Commission and HCFA audits.

- At the Graduate Health Care System in the Philadelphia area, four hospitals and several hundred physicians are continuously on-line to an integrated lifetime patient record. This means that when patients are admitted to any hospital in the Graduate system, or are seen by any area physician with privileges, all patient information is immediately available. This dramatically simplifies care management and charting in both hospitals and physicians' offices. In some departments, workloads have increased as much as 33% without additional staffing.

- The New York City Health and Hospitals Corporation, the largest non-Federal public health care provider in the country provides integrated care in 11 hospitals (10,500 beds), five long term care facilities, and numerous outpatient clinics. The Corporation is installing a fully automated patient care system. In its evaluation, the Mayor's Private Sector Survey determined that the HIS system which is designed to provide a lifetime clinical record with access from anywhere in the city, provided for *complete payback in six months.*

Benefits of Clinical Applications

In summary, state-of-the-art hardware and software already available from HIS companies can significantly decrease the amount of time health professionals must spend delivering "paper care" instead of patient care. A study by Auther D. Little has determined that appropriate automation of clinical information alone could save $30 billion. These systems save money, improve the quality of care, and facilitate review and research.

On-line integrated patient-centered-systems assure that the proper information necessary for making both clinical and administrative determinations about a patient's status is collected as it becomes available and delivered when and where it is needed, rather than being managed in separate steps after the event, a process which introduces significant costs and exposure to error. Explicit benefits emerge from such applications. Examples include:

- Point-of-care based automation allows appropriate screening of data to be performed as care is being given, whether it be at the bedside, in the examining room, or in a physician's office. Because data is captured in real time, it can be checked for appropriateness, completeness, and errors as care is delivered.
- Detecting potential problems as they occur enhances quality and eliminates the large numbers of administrative staff who now attempt to detect such problems retrospectively.

- Because of the clerical burden in the delivery of patient care, most integrated patient-centered systems have been shown to save from one-half hour to one and one-half hours per provider per shift when properly implemented. Because 60-80% of health care operating costs are personnel costs, this amount of time saving can provide a significant level of cost reduction.

- Purchasers of such systems have typically experienced a payback on the investment in two to three years with a seven-year useful life of the equipment. Larger users have even faster returns on their investments.

Finally, the automation of the bulk of the clinical record allows the extraction of information necessary to perform medical care appropriateness and reasonableness oversight. It also supports the kind of medical effectiveness research currently being undertaken by the Agency for Health Care Policy and Research and others. With the on-line availability of most or all clinical and financial data, quality assurance and utilization review activities can be performed at central sites in an automated fashion, rather than on a case-by-case basis using expensive chart reviewers.

As practice parameters, case management, care maps, and other concurrent control mechanisms are put into place the required amount of monitoring staff increases. The ability to monitor such control mechanisms both within the institution and at payer locations using largely automated techniques will enhance the quality of care, and will significantly decrease the cost and increase the quality of the evaluation process. Better still, the availability of uniform data as recommended later in my testimony will make such reviews more fair and more reliable.

As an example of the kind of studies that could be conducted with greater speed and reliability, let us consider outcomes research taking place on therapies for prostatic disfunction in men. There are essentially three ways to study such a condition. The typical prospective study would collect data from a small (100-300) sample of patients, then analyze and report on its findings. This method requires a significant investment in time, often recollecting data that might have been available at the time the patient was first seen by his physician. Alternatively, 500 patients might be retrospectively considered such as in projects currently being conducted by the Agency for Health Care Policy and Research. However, the preferred method would be to draw the information from clinical records already being maintained on the universe of prostate patients, improving both the speed of the study and the reliability of the findings. Medicare is already paying for hundreds of thousands of such evaluations, but the results are not available for outcomes analysis.

To be effective, it is important to emphasize, that *complete* data be collected at the point of care, not just abstracts -- an abridged summary of the medical record, gathered after the fact -- as some would recommend. Complete, concurrent data is needed to make better policy decisions on a broad scale.

HIMA believes the administrative simplification provisions of HR 200 would greatly expedite the movement toward a more efficient and effective health care delivery system. The key to achieving these goals as pointed out in HR 200 lies in establishing the uniform use of standardized comprehensive non-abstracted data elements and data sets for both claims processing and medical records.

INCENTIVES FOR RAPID IMPLEMENTATION

Standardized Information

Because HIS companies provide systems that manage clinical and financial data which must be shared with a wide array of interested parties, the question of information standards becomes essential. It is clear that the better and more comprehensive the standards for health care data interchange, the better the integrity of the data reaching providers, payers, reviewers, and researchers. Informatics standards should govern communications regarding the complete range of activities from claims processing to direct clinical care. Additionally, the standardization and automation of the bulk of the clinical record allows the rapid extraction of information necessary to perform care appropriateness and reasonableness review, and to support the kind of medical effectiveness research currently underway by the Agency for Health Care Policy and Research and other outcomes oriented groups.

In the health care industry, a number of independent entities need to store and share information (*e.g., hospitals, physicians' offices, payers, utilization review agents, and researchers). Many providers have invested in HIS software to store and retrieve data for a variety of purposes. One of the functions that comprehensive HIS software accomplishes is communication among providers of patient care, payers (both public and private), and utilization review agents. Increasingly, those performing outcomes research should also be able to take advantage of these improvements. It is then that the greatest strides in care quality will be realized as providers have more rapid access to the latest information on treatment modalities.

Informatics standards enable efficient communication through electronic data interchange. Standards should specify the discrete items and kinds of information (data elements) that are needed for each type of communication, and the format of those data elements. This enables entities to communicate with one another even if they all have customized computer software from several different companies. An information user need not require that providers have a specific HIS software package to achieve these savings whether for claims management or patient care. Hospitals and physicians' offices may purchase different HIS systems, but still communicate easily if the information to be exchanged is standardized.

State lines present another potential stumbling block. If informatics standards are permitted to vary from state to state -- as might occur if a plan is developed that encourages states to experiment with reporting requirements -- providers, and ultimately payers, will incur higher costs to acquire software to meet these varied requirements. Additionally, software for hospital systems that serve patients in more than one state would be significantly more complex and costly. And, the clinical, quality, and cost data for each state will be incompatible for analyses of the efficiency and efficacy of care. Therefore, while payment systems may themselves differ, states should not be able to request exemptions from using uniform national informatics standards.

The bulk of the efficiencies and savings will not be achieved unless all health care entities conform to uniform national standards. Judging from early analyses of likely health reforms, the vast majority of providers may continue to treat patients covered by a variety of health benefit plans. Without extensive standardized clinical data, the value and quality of such care will be impossible to estimate. Hospitals and physicians are likely to need to communicate with a variety of payers, utilization and quality assessors, and others. If providers continue to be faced with the current incompatible requirements, then they will also continue to spend increasing time and money training staff to manage more complex requirements. *HIMA believes that mandating truly uniform bill formats, with uniform data elements, and comprehensive uniform clinical data sets would be one of the simplest mechanisms for gaining immediate system-wide administrative savings.*

The American National Standards Institute (ANSI) has created the Healthcare Informatics Standards Planning Panel (HISPP), with extensive participation of providers, payers, and HIS manufacturers, to coordinate the development of informatics standards. HISPP directs an interactive process for all electronic data communications in health care. When similar information must be communicated for more than one purpose, HISPP ensures that the various standards do not impose incompatible formats for that information. If additional standards become a part of the future health system, HIMA recommends that HISPP coordinate their development to avoid duplication of effort and incompatibility with existing standards. If standards are developed without such coordination, providers and payers will bear the costs.

Increased Spending on Information Infrastructure

As noted above, the health care system in the United States spends considerably less money on information support than do other information industries. The operational problems generated by this low level of spending are compounded by a far higher level of spending for highly trained health care providers to perform administrative chores that should be automated. Improved availability of capital resources would assist in rectifying this impediment to effective and efficient health care delivery. Incentives which encourage investment in providers' information infrastructure rather than in physical plant would be a significant benefit. Such incentives could be in a number of forms including financial benefits such as adjustments to payment formulas, participation requirements based on-line availability of standard clinical data and the like.

* * * * *

In conclusion, a wealth of benefits can be derived from the full implementation of health care information systems. HIMA believes that mandating a truly uniform bill format with uniform data elements and codes, accepted by all insurers and public payers would be one of the simplest mechanisms for obtaining immediate health care system-wide administrative savings. HIMA also believes that uniform comprehensive clinical data sets would provide major cost savings, and would greatly facilitate patient care and outcomes research, crucial needs for any reformed system. Better clinical and financial information and rapid access to it will provide improved health care delivery by clinicians, better quality of care for the patients, and greater efficiencies and effectiveness for the aggregate health care system.

More significant savings come from on-line clinical information available with rapid access. Such systems provide greater efficiencies for direct health care providers and improves health care delivery and health care quality. Additional savings will come from using such systems to determine the adequacy, appropriateness, and sufficiency of services, especially those that and do so in real time before costs are expended. These procedures, such as utilization review, quality assurance, and other concurrent and post treatment analyses are a major focus for both providers and payers and are a key to both the cost and the quality of care. Examination of the administrative overhead invested in accumulating these parameters reveals a large number of additional areas where costs can be reduced or eliminated by the use of clinical systems which can deliver large amounts of standardized clinical data. Importantly, such electronically available clinical information provides the necessary infrastructure for accurate national outcomes assessment.

The U.S. health care system has increasingly found itself a victim of an unwinnable paper chase. Providers and payers both spend a major portion of their time and resources performing administrative tasks which are often duplicative or conflicting. The technology already exists for addressing many of these areas but for a variety of reasons has not been widely implemented. The health care information system companies were among the first to realize the potential benefits of the applications being reviewed by the Subcommittee on Health. We believe that even greater potentials will be found as these systems are more broadly examined. HIMA members who will provide the systems to effect the savings and other improvements can facilitate the transition to a fully automated system. We would welcome working with the Subcommittee to provide continuing industry information on actual system capabilities. We look forward to assisting the Subcommittee in this and in other ways.

Chairman STARK. Mr. Clarke.

STATEMENT OF RICHARD L. CLARKE, PRESIDENT, HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION

Mr. CLARKE. Good afternoon, Mr. Chairman, Mrs. Johnson. My name is Richard Clarke, and I am pleased to be here today on behalf of the Healthcare Financial Management Association.

HFMA represents over 31,000 individuals involved in the financial management of various types of health care organizations, including hospitals, clinics and third-party payers. I have served as the president of the association for the past 7 years, and I appreciate the opportunity to add to our written testimony on health care administrative costs and our approach to simplifying the processes associated with these costs.

HFMA agrees that there is compelling need for uniformity and simplicity in health care administrative procedures. Moreover, the administrative simplification can and should be done now.

After an in-depth consultation with our members and others, we have developed a detailed plan to try to achieve this goal. Our plan, Mr. Chairman, is similar to the approach that you took in H.R. 200 and the approach that Senator Bond described earlier today. That is, we propose to simplify current health care administrative procedures through the mandated use of standardized electronic processes for all participants in the health care delivery system. I urge you and the members of this committee to consider this approach when discussing possible solutions to the current problems of health care administrative processes. Health care financial managers and others who are involved in these processes have confirmed that our approach is feasible and could be implemented in the very near future.

Mr. Chairman, while HFMA supports comprehensive health care reform, we also recognize that it may take some time before reform is enacted and implemented. However, administrative simplification must begin now. HFMA's proposal can be enacted independently of overall health care reform. In fact, development of standardized and uniform electronic processes is an essential first step toward any reform effort.

Mr. Chairman, HFMA's proposal would simplify and standardize the health care administrative functions of enrollment, eligibility, coordination of benefits, billing, remittance and payment for all health care providers and third-party payers. This would be accomplished through the creation of a mandated system to provide universal electronic processes to be used by all health care providers and third-party payers while allowing some alternative mechanisms for smaller providers and smaller employers.

The proposal also would create an independent health care administrative commission to recommend to the Secretary of the Department of Health and Human Services uniform definition and standards for administrative functions.

I would like to explain why a mandated system is so important. For several years, health care providers and third-party payers have worked toward the development of uniform forms. Our efforts thus far have been inconsistent because participation is voluntary. In other words, uniform forms have not been used uniformly. And,

despite these voluntary efforts, without mandates there will be no uniformity.

We believe simplification of health care administrative processes and systems will not occur without changes to current law that require all parties to adopt uniform standards of electronic processes.

Earlier this year, HFMA contracted with Lewin-VHI, a nationally recognized, independent consulting firm, to research the potential cost savings from the implementation of HFMA's approach to administrative simplification. Briefly, that study found that in 1991 administrative costs totaled approximately $126 billion or 17 percent of total health care expenditures. It also identified that it would cost approximately $800 million per year to implement HFMA's proposed administrative simplification process, yet it would yield a savings of between $3.4 and $6 billion annually.

Mr. Chairman, these savings are significant and could begin now if administrative simplification is achieved. The proposal we have outlined for you today can be integrated effectively in the current system, yet it could function within any new system.

On behalf of the members of HFMA, I appreciate the opportunity to appear before you today. We look forward to working with you as well as other Members of Congress, the administration and our health care partners in trying to create national standards that will streamline administrative burdens and control costs.

Thank you.

Chairman STARK. Thank you, Mr. Clarke.

[The prepared statement and attachments follow:]

STATEMENT OF RICHARD L. CLARKE, FHFMA
BEFORE THE
HOUSE WAYS AND MEANS COMMITTEE
SUBCOMMITTEE ON HEALTH
REGARDING HEALTHCARE ADMINISTRATIVE SIMPLIFICATION

Tuesday, May 25, 1993

Good morning, Mr. Chairman and members of the Subcommittee. My name is Richard L. Clarke, and I am here today representing the Healthcare Financial Management Association. I am a Fellow of HFMA and have served as President of the Association for the past seven years. Prior to that, I worked in the healthcare financial management field for 15 years in patient accounting and as a chief financial officer. HFMA represents more than 31,000 professionals involved in the financial management of various types of healthcare institutions, including managed care providers, and public accountants, consultants, insurance companies, governmental agencies and other organizations. On behalf of these individuals, I appreciate the opportunity to present our views on healthcare administrative costs and to offer an approach to simplifying the processes associated with these costs.

Given the geographic and professional diversity of its members, HFMA is in a unique position to identify the problems associated with the current healthcare claims and patient accounting processes. Based on our analysis of the system, we have determined there is a definite need for uniformity and simplification. Moreover, administrative simplification can and should begin now. After in-depth consultation with our members and others, we have developed a detailed plan to achieve this goal.

HFMA PROPOSAL FOR HEALTHCARE ADMINISTRATIVE SIMPLIFICATION AND UNIFORMITY

Mr. Chairman, HFMA's proposal will simplify current healthcare administrative processes through the mandated use of various electronic processes for all participants in the healthcare delivery system. On behalf of the Association, I urge you and the members of your Subcommittee to consider this proposal when deliberating possible solutions to the current problems with the healthcare administrative process. Our proposal has been reviewed by healthcare financial managers and others involved with these processes. These professionals have confirmed that the concepts contained in our proposal are feasible, practical and will meet the goals of the Congress, the Administration, the healthcare community, and most importantly, the consumer.

Mr. Chairman, HFMA's proposal can be enacted with or without overall healthcare reform. While a total overhaul of the healthcare system is essential, enacting a comprehensive reform package may take longer than anticipated. Administrative simplification, in and of itself, will result in savings to the healthcare system, thereby increasing the availability of public and private funds that can then be directed to other essential areas of the healthcare delivery system.

Very briefly, if enacted, HFMA's proposal would simplify and standardize the healthcare administrative functions of enrollment, eligibility, coordination of benefits, billing, and payment for all healthcare providers and third-party payers. This would be acomplished through two primary initiatives:

- The creation of a system to provide universal electronic processes for healthcare enrollment, eligibility, coordination of benefits, billing, remittance, and payment to be used by all healthcare providers and

third-party payers, while allowing alternative mechanisms for smaller providers and employers.

- The formation of an independent healthcare administrative commission, comprised of representatives from the industry and the government, to recommend to the Department of Health and Human Services uniform definitions and standards that will permit the creation of the universal claims process system; and to provide Congress and the Secretary with an ongoing assessment of the system.

These two primary initiatives would:

- Apply to all private and government-sponsored healthcare benefit plans.

- Assure the development of an electronic system that provides a universal administrative process for the healthcare industry.

- Provide rules and information transfer mechanisms to facilitate coordination of benefits and Medicare Secondary Payer programs.

- Implement a system that will make use of a nationally acceptable electronic transmission standards.

- Allow healthcare providers (including rural and small providers), payers, and sponsors unable to use the electronic transmission systems, to alternatively use clearinghouses.

- Provide that these provisions would preempt any state or local laws addressing hard copy documentation of medical, healthcare benefit plan records or data, or confidentiality.

DISCUSSION OF THE PROBLEM

For several years, healthcare providers and third-party payers have worked toward administrative uniformity. While it is generally agreed that this is essential, our efforts to achieve it thus far have been inconsistent, because acceptance and utilization of the standardized formats created by various healthcare groups are voluntary. HFMA believes that total uniformity of healthcare administrative processes and systems will not be accomplished without changes to current law to require all providers and third-party payers to adopt uniform, standard, electronic processes. Without such a requirement, the administrative process will remain complex and cost inefficient.

HFMA's analysis of the administrative burdens currently placed on the healthcare industry can best be summarized by the following points:

- Standard uniform formats and processes for healthcare claims are readily available, but not used consistently by all participants of the healthcare delivery system.

- With most systems, any request for additional information that is not included on the original electronic form will result in the submission of paper documents, thereby negating the advantages of an electronic transmission.

- Current development of electronic data interchange standards have included data transmission standards, but there is no uniform convention for the use of these standards. Any movement by the industry must require uniformity or the industry will be compelled to maintain costly multiple systems.

HFMA COST STUDY

It is widely held that inefficiencies in the current administrative processes are a major contributor to the high cost of healthcare. To substantiate this theory, the Association contracted with Lewin-VHI, a nationally recognized independent consulting firm, to research the potential cost savings once simplification is realized. The study found:

- 1991 administrative costs totaled approximately $126 billion, or 17 percent of total health expenditures.

- Administrative costs can be broken down into three components: $45 billion was spent by hospitals; $43 billion was spent by physicians; and $38 billion was spent by payers.

- It would cost approximately $800 million per year to implement HFMA's proposed administrative simplification processes.

- Implementation of HFMA's legislative proposal would save $3.4 to $6.0 billion annually.

ACTIVITIES OF THE INDUSTRY TO ACHIEVE UNIFORMITY

Over the past 20 years, HFMA participated on the National Uniform Billing Committee, working closely with other healthcare representatives and the government. The NUBC established the UB-82, a uniform bill form and accompanying data set. The UB-82 was designed to provide a uniform format for the submission of hospital-based claims. Although the UB-82 satisfied the goals of a uniform bill, due to a variety of factors, some payers began requiring additional information that was not contained on the uniform bill.

Currently, there are about 50 different versions of the UB-82, representing the variances of each State Uniform Billing Committee. There are also as many as 420 different electronic versions of the UB-82, representing various payer versions of this data set.

The UB-82 provided an official data set and format; however, usage is largely voluntary. Official formats, data sets, and standards are important, but without uniformity, there are no savings. Our members find themselves faced with hundreds of modifications to their systems each year to meet the different versions of this "uniform bill."

The UB-82, approved by the Office of Management and Budget for use in the Medicare program, will be replaced by the UB-92, with a scheduled implementation date of October 1, 1993. The conversion represents two and a half years of work by the NUBC. Medicare providers have been given three months to initiate final conversion to this form.

In addition to the UB-92, the HCFA 1500 form also is used generally by providers for ambulatory and physician billing. Initially it was only used for Medicare, but recently others in the healthcare community have broadened its use. Since the Medicare Program requires all physicians and clinics to bill using the HCFA 1500, many have found it easier to perform all of their billing on the HCFA 1500 rather than use other forms.

It should be noted that the HCFA 1500 and the UB-92 share approximately 95 percent of the same data elements. Even with the availability of the HCFA 1500 and the impending implementation of the UB-92, however, the use of these forms is, and will continue to be, inconsistent. HCFA and other payers may require supplemental claims forms for certain healthcare services. They may also require multiple forms to satisfy the need for additional requisite information. State laws do not necessarily prevent this situation since, in many cases, the transactions are either regulated by the Federal government or are required by out-of-state payers or administrators. Alternatively, ERISA based self-insurance plans are exempt from any state legislative initiatives attempting to alleviate a state-specific problem.

A provider's economic health is dependent upon the prompt payment of claims. Therefore, providers will continue to respond to payer demands for additional data in different formats. This increases the provider's administrative costs, resulting in higher overall healthcare costs.

RELATIONSHIP OF THE INDUSTRY WITH ANSI AND WEDI

In 1989, representatives of several of the nation's larger insurance companies and banks sought to eliminate the use of checks to pay for healthcare claims. Healthcare payers, including HCFA, and providers concerned about the problems and limitations previously noted joined forces with the insurers and banks to form the Insurance Subcommittee of the Accredited Standards Committee (X12) of the American National Standards Institute. ANSI directed the X12 to develop standard data transmissions between business partners.

Through the ANSI X12 and other subgroups, payers and providers have suggested electronic data interchange and electronic funds transmission standards to allow for the electronic transmission of large amounts of data and funds. To date, draft standards have been developed for enrollment, eligibility, claims, and payment. Task groups have also undertaken projects addressing issues such as utilization review data, crossover or coordination of benefits billing, claim status, first report of injury and other healthcare related data exchanges.

In late 1991, the HHS Secretary convened a summit with the leaders of several of the nation's health insurance companies. The Workgroup on Electronic Data Interchange, or WEDI, was a by-product of this summit. The WEDI group, which included a small representation of healthcare providers, was directed to evaluate the use of ANSI X12 standards in the healthcare industry. After several months of deliberating, a

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While not minimizing the work of the WEDI group, the group did not fully represent all necessary participants of the healthcare community. Consequently, the report's recommendations do not reflect the essential elements to establish a strategic plan for implementation of a standardized system. Furthermore, the report recommends legislative action only after it becomes apparent that voluntary compliance is not effective. HFMA contends that given the past experiences with voluntary efforts and the need to accelerate the process toward administrative simplification, Congress must enact legislation to mandate compliance now.

CONCLUSION

Mr. Chairman, while HFMA advocates comprehensive healthcare reform, we urge you and the members of your Subcommittee to enact legislation now to simplify and standardize the healthcare administrative processes and not wait for a complete reform package. The proposal we have outlined for you today can be effectively integrated into the current system, yet it will also function within any new system. The time to begin moving toward change is now.

Mr. Chairman, I have appended to this statement an executive summary outlining HFMA's administrative simplification proposal, and a copy of our study illustrating the cost savings to be derived from that proposal. I respectfully request that these documents be included in the record immediately following my statement.

On behalf of HFMA, I appreciate the opportunity to appear before you today and present the organization's views on healthcare administrative costs. With more than 31,000 members engaged in the management of healthcare financial operations, we are available to provide guidance to you as decisions are made on simplifying the system. We look forward to working with you, as well as other members of the Congress and the Clinton Administration and, of course, our partners in the healthcare community. Together we must plan the steps necessary to create a national standard, thereby improving our industry, lowering the administrative burdens of health care, and controlling the unnecessary costs brought about by duplication of efforts and paper processing. Thank you.

HEALTHCARE ADMINISTRATIVE SIMPLIFICATION AND UNIFORMITY ACT EXECUTIVE SUMMARY

HFMA proposes the enactment of legislation to:

- Establish national uniform electronic processes for various functions associated with many healthcare administrative procedures to be used by all healthcare providers and third-party payers.
- Establish an independent commission reporting to Congress, to create and monitor these processes and any others that may be needed in the future.

Establishment of A Healthcare Administrative and Assessment Commission

- A Healthcare Administrative and Assessment Commission (Commission) based on the Prospective Payment Assessment Commission would be established.
- The Commission would report to Congress and work in coordination with the Secretary of the Department of Health and Human Services and the healthcare industry.
- The Commission would be comprised of a cross-section of the healthcare industry -- sponsors, payers/administrators, providers and suppliers, professionals, regulators, and vendors, thereby involving both the public and private sectors.

Compliance

- The legislation would require participation by all healthcare providers and third-party payers.
- The legislation would require the development of clearinghouses for data transmission by parties that do not initially have the necessary electronic transmission capabilities or, due to size, may not find electronic transmission financially feasible. In the area of claims and payment transmission, clearinghouses would eventually cease to exist as they are currently known due to the introduction of universal edits.
- The Commission would be charged with creating incentives to encourage compliance and penalties for failing to comply.
- Benchmarks would be established by the Commission to determine the level and costs of participation, and this information should be reported to Congress annually. Monitoring of costs will ensure that the networks needed to conduct data do not become prohibitive due to cost.

Establishment of Healthcare Eligibility and Enrollment Mechanisms

The Commission would:

- Determine a mechanism to permit the electronic transmission and receipt of healthcare benefit plan enrollee benefits and coverage among the healthcare partners;
- Make use of a nationally acceptable electronic data interchange;
- Determine all the data elements within an official healthcare enrollment and eligibility data set and determine uniform definitions of all the data used under the direction of the Commission; and

- Annually review the selected mechanisms, definitions, and data sets to ensure that all needs are met in this era of changing needs and new technology.

The Secretary would be required to:

- Publish regulations and set implementation dates, in consultation with the Commission in accordance with the Administrative Procedures Act and the Negotiated Rule-Making Act; and

- Initially establish the needed entities, run at cost or by a private concern in areas of the country where clearinghouses may not be available.

Establishment of Healthcare Billing, Remittance, and Payment Mechanisms

- The mechanisms would be similar to the functions of enrollment and eligibility determination.

- The Commission would determine the mechanism to permit the electronic transmission and receipt of data on billing, remittance, payment, and other supporting data among healthcare partners.

- Once uniformity and standards are established, the industry would achieve one of its more evasive goals--a uniform claim form and claims process.

Preemption of Quill Pen Laws, Changes in Privacy and Confidentiality Protection, and Uses for Data

Some laws exist at local, state, and Federal levels that can prohibit or delay the implementation of these recommendations. The legislation would include legislation to preempt the appropriate laws which are in conflict with any other provisions of this Act.

REDUCING ADMINISTRATIVE COSTS IN A PLURALISTIC DELIVERY SYSTEM THROUGH AUTOMATION

Prepared For:

Healthcare Financial Management Association

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April 30, 1993

EXECUTIVE SUMMARY

REDUCING ADMINISTRATIVE COSTS IN A PLURALISTIC DELIVERY SYSTEM THROUGH AUTOMATION

Considerable confusion surrounds the issues of administrative costs and efficiencies in the U.S. healthcare system. Paperwork inefficiencies, in particular, are often identified as a source of cost savings, but specific proposals and supporting analyses generally are lacking. One proposal to reduce paperwork inefficiencies is the Healthcare Simplification and Uniformity Act of 1993, developed by the Healthcare Financial Management Association (HFMA). This proposal, if enacted, would establish national, uniform, electronic processes for various functions associated with common healthcare administrative procedures. In this study, Lewin-VHI attempts to synthesize a best estimate of healthcare administrative costs from the literature, and to determine the savings potential of the proposed HFMA bill.

Our study estimate of 1991 total administrative costs is $125.6 billion, or 17 percent of total health expenditures. Broken down by component, our study estimates are $44.7 billion in hospital administrative costs, $43.3 billion in physician administrative costs, and $38.1 billion in insurer administrative costs.

Implementation of the HFMA proposal could reduce these costs. Automation would expedite and simplify administrative functions such as: claims processing, payment and accounting, and enrollment and eligibility. Uniform data transmission formats would be created to replace the more than 400 different formats currently in use. As a result, savings would accrue in all three component sectors of administrative costs. We estimate that the HFMA legislative proposal will cost nearly $800 million per year to implement, but annual net savings would range from $2.6 to $5.2 billion, or 2.0 percent to 3.9 percent of total administrative costs. The range of values arises from a difference in estimates of claims processing savings.

While the proposed Healthcare Administrative Simplification and Uniformity Act would yield administrative savings, it is also important to understand that many non administrative benefits would emerge if automation were extended to clinical systems. Automation on the scale of the HFMA proposal would provide healthcare managers with the data they need to be effective. Currently, such data representing private sector transactions are lacking, as individual employers' and insurers' databases are usually too small to enable reliable comparisons of charges and episodes of care, and aggregating non uniform data is a nearly impossible task. HCFA projects that the automation and aggregation of clinical data alone could save nearly $18 billion in 1993 by reducing the incidence of diagnostic tests, reducing length of stay, making hospital staff more efficient, and improving the overall quality of care.

The availability of large-scale, uniform, service-level databases would be an invaluable tool for appraising the performance of healthcare organizations and the efficacy of different treatment options. Standardization reduces error and permits comparison. The implications of automation for healthcare reform are clear: reliable data would foster accurate comparisons of fee-for-service and managed care, evaluations of private and public sector benefit plans, and setting of budgets. In essence, electronic highways and automated data transmission are a necessary component of any attempt at health reform.

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A. INTRODUCTION

Despite much discussion, considerable confusion surrounds the issues of administrative costs and paperwork inefficiencies in the U.S. healthcare system. In order to proceed, decision-makers need a resolution of two fundamental points. First, there is no universally accepted, bottom line estimate of total administrative costs. Second, and perhaps more importantly, there is uncertainty as to the administrative savings potential of various aspects of healthcare reform.

One proposal to achieve administrative cost savings is the Healthcare Administrative Simplification and Uniformity Act of 1993, developed by the Healthcare Financial Management Association (HFMA). This proposal, if enacted, would establish national, uniform, electronic processes for various functions associated with common healthcare administrative procedures. The proposed bill is premised on the belief that the combination of uniformity of data processes and simplification of administrative tasks through automation will achieve significant administrative and system efficiencies.

HFMA commissioned Lewin-VHI to investigate the issues raised above. Specifically, what value or range of values represents a "best estimate" of administrative costs? And, to what degree, if any, will the proposed HFMA bill produce administrative savings? To determine a "best estimate" of administrative costs Lewin-VHI has reviewed several recent studies which have attempted to ascertain the cost of healthcare administration. From these, a synthesis estimate of costs, categorized by payer and provider, is given. The paper next provides a description of the HFMA proposal, including its provisions, its scope, and a conceptual framework for understanding networks of communication in the healthcare system. Estimates of expected savings from the proposed bill follow. The paper concludes with an attempt to understand some of the broader implications of the HFMA proposal, including the role of uniform data in managing medical treatment and in supporting the process of healthcare reform.

B. THE ADMINISTRATION OF HEALTH CARE IN THE UNITED STATES

1. Characteristics

Much of the cost of administering health care in the United States can be traced to the fact that insurance is provided through roughly 1,500 separate private and public sources of coverage, each with its own rules, forms, and provider reimbursement policies.[1] Moreover, the U.S. healthcare system is characterized by multiple-billing schemes, whereby providers must often submit separate claims or bills to two or more entities or individuals. Multiple-billing occurs when individual services are covered by more than one payer (e.g. Medicare and Medigap), and when patient cost-sharing requires providers to first file with the insurer and then bill the patient for the unreimbursed amount.

Other significant cost-producing characteristics of healthcare administration are the tendency among small firms to switch insurers frequently, audit and reconciliation

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1 Sheils, John F., Gary J. Young and Robert J. Rubin, "O Canada: Do We Expect Too Much from its Health System," Health Affairs, Spring 1992: 9.

requirements for public programs, and efforts by insurance companies to assure appropriate, cost-effective care by requiring advance notification, second opinions, etc. This last feature is of particular interest, as it casts some uncertainty onto the push to minimize administrative burden. In theory, requiring providers to fill out more forms and obtain approval for various procedures serves to reduce the amount of unnecessary care and, thus, helps to control rather than raise overall costs.[2] The implications for administrative reform are clear: A balance must be struck so that efforts to increase administrative efficiency are not undertaken without reference to costs, savings, and clinical concerns elsewhere in the healthcare system.

2. Cost Estimates

The literature provides several estimates of administrative costs. We reviewed studies conducted by the following organizations: the United States General Accounting Office (GAO)[3], the Congressional Budget Office (CBO)[4], Lewin-VHI[5], and Cambridge Hospital/Harvard Medical School[6]. The actual dollar figures, computed for three components of healthcare administration, are identified in Table 1 below:

Table 1
Administrative Cost Estimates

(1991 Dollars in billions)[7]

Author	Hospital	Physician	Insurer	Total
GAO	$43.7	$31.9	$42.8	$118.4
CBO	$41.0	$45.9	$38.6	$125.6
Lewin-VHI	$93.9	$43.3	$38.2	$135.1
Harvard I	$47.0	$30.8	$30.2	$108.0[8]
Harvard II	-------	$59.0	------	-------

2 Danzon, Patricia M., "Hidden Overhead Costs: Is Canada's System Really Less Expensive?," Health Affairs, Spring 1992: 26.

3 United States General Accounting Office, Canadian Health Insurance: Estimating Costs and Savings for the United States, April 1992. The GAO administrative cost estimates cited in this paper are Lewin-VHI calculations based on GAO estimated savings under a single-payer system.

4 Congressional Budget Office, Universal Health Insurance Coverage Using Medicare's Payment Rates, December 1991. The CBO physician and hospital estimates cited in this paper are Lewin-VHI calculations based on CBO combined estimate of provider administrative costs.

5 Sheils, John F., Gary J. Young and Robert J. Rubin, "O Canada: Do We Expect Too Much from its Health System," Health Affairs, Spring 1992: 7-20. This Lewin-VHI estimate was conducted as part of a prior study. Therefore, our estimate for this paper, which is a synthesis of various estimates in the literature, differs from the prior Lewin-VHI figure.

6 Woolhandler, Steffie and David U. Himmelstein, "The Deteriorating Efficiency of the U.S. Healthcare System," The New England Journal of Medicine, 2 May 1991: 1253-1258.

7 1991 Dollars computed using yearly Changes in Consumer Prices for all items. Source: Economic Indicators: December 1992.

8 Does not include $6.4 billion in estimated nursing home administrative costs (1987 dollars).

Discrepancies in what is being defined and measured as administrative costs and differences in estimation methodologies account for the range of values evident in the above table. In the following section, we discuss these estimates and produce a synthesis estimate.

a. Hospital Administrative Costs

At a glance, the Lewin-VHI estimate of hospital administrative costs ($93.9 billion) is an outlier. This figure, however, comprises numerous cost categories omitted from the other estimates. For example, the Lewin-VHI number includes costs attributed to the administration of educational and research programs, depreciation, amortization, leases and rentals, licenses and taxes, and other unassigned costs. In addition, net revenues, non operating expenses, and the cost of various general services (e.g. cafeteria, security, housekeeping) are added in to compute total costs. While these categories represent valid components of healthcare overhead, we eliminated them from the Lewin-VHI estimate when we calculated our synthesis estimate in order ensure that the same base of administrative cost categories was included in our synthesis calculation.

The additional categories in the Lewin-VHI hospital estimate account for $40.3 billion of the $93.9 billion in total administrative costs. Subtracting these costs leaves an adjusted hospital estimate of $53.6 billion. The median of the GAO, CBO, Harvard, and adjusted Lewin-VHI hospital estimates is $45.3 billion, which we will use as our study synthesis estimate for 1991 hospital administrative costs. The mean is $46.3 billion. The range of estimates is $41.0 - $53.6 billion. If the additional categories in the original Lewin-VHI figure were to be added back in, the mean hospital estimate would be $56.4 billion, but the median estimate would remain at $45.3 billion.

b. Physician Administrative Costs

On the physician side, all estimates appear to incorporate analogous cost categories. However, disparate methodologies account for differences in the results. The Harvard study presents two estimates of physician administrative costs. The lower estimate is computed using a personnel-based approach, by which the average time spent by physicians, clerical workers, and managerial staff on administrative functions is assigned a monetary value. The costs of outside billing services are then added to this figure, yielding a 1991 estimate of $30.8 billion. The higher estimate, $59.0 billion, is calculated based on estimates of physicians' overhead and billing expenses.

According to the authors of the Harvard study, the expense-based method may overstate administrative costs since it assumes administrative activities account for the entire difference in the proportion of income devoted to professional expenses between physicians in the United States and in Canada. Likewise, the personnel-based method may understate costs as it assumes that aides and other clinical personnel employed in physicians' offices perform no activities related to billing.[9]

Our study synthesis estimate of 1991 physician administrative costs - the median of the Harvard overhead, Harvard personnel, GAO, CBO, and Lewin-VHI estimates - is $43.3 billion. The mean of these five physician estimates is $42.2 billion. The range of estimates is $30.8 billion to $59.0 billion.

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9 Woolhandler and Himmelstein: 1256.

c. Insurer Administrative Costs

All estimates of insurance administrative costs appear to incorporate analogous cost categories. Computing the median of the four figures yields a 1991 study synthesis estimate of $38.4 billion. The mean is $37.5 billion and the range is $30.2 billion to $42.8 billion.

d. Study Synthesis Estimates of Administrative Costs

Our study synthesis estimates for the components of administrative costs are summarized in the table below. The final column of the table contains our study synthesis total. The GAO estimates 1991 total health expenditures at $737.0 billion.[10] Therefore, our estimate of $125.6 billion in total administrative costs represents 17 percent of total health expenditures.

Study Synthesis Estimates (1991 dollars in billions)

Hospital	Physician	Insurer	Sum of Component Medians[11]	Median of Totals[12]
$44.7	$43.3	$38.1	$126.1	$125.6

C. THE HFMA LEGISLATIVE PROPOSAL

The Healthcare Administrative Simplification and Uniformity Act of 1993 as proposed by HFMA calls for "the establishment of national, uniform, electronic processes for various functions associated with many healthcare administrative procedures and the establishment of an independent commission to create and monitor these processes and any others that may need future development".[13] In summary, the proposal creates a commission to standardize and simplify:

- the formats used to transmit information between healthcare entities;
- the content of the transmitted data sets;
- the mechanisms by which information is exchanged.

The goal is to establish uniform processes such that the various organizations and entities within the healthcare system can "talk" to each other electronically and efficiently. The standardization of formats for data exchange may eliminate the most significant barrier to efficient electronic communication. A format may be thought of as the equivalent of a spoken language. Transmitted in different formats, the same pieces of information may be ordered differently or represented by unlike symbols. Currently, there are more than 400 different

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10 GAO: 8.
11 Calculated by summing first three columns of table.
12 Calculated by computing the median of total GAO, CBO, Lewin-VHI, and Harvard estimates.
13 Healthcare Financial Management Association, "The Healthcare Administrative Simplification and Uniformity Act of 1993".

electronic formats in use.[14] These formats are used to transmit information related to the delivery and financing of health care, including enrollment, eligibility, benefit coverage, and claim and payment information. The creation of common formats for all types of data exchange would remove a formidable obstacle to the efficient flow of information.

Aside from standardizing formats, the proposal seeks to create uniform contents for the actual data sets that are exchanged. For instance, all data transmitted from hospitals to private insurers would contain the same variables describing patient characteristics, services rendered, etc. As a result, payers would know exactly what data they were getting from each hospital, and would be able to compare the same data across different hospitals. In the same manner, providers would be able to obtain uniform data concerning covered patients under various benefit plans.

Finally, the proposal seeks to fully automate the mechanisms by which information is exchanged among providers, payers, and other organizations involved in the financing and delivery of health care. Many facets of the healthcare system are already automated. Medicare, for example, processed 92.2 percent of hospital inpatient claims and 89.9 percent of hospital outpatient claims electronically from October 1991 to August 1992.[15] The HFMA proposal not only would require electronic claims submission, but would encourage automation of billing and payment functions.

In practice, the HFMA proposal would foster some sort of automated communication network - or "electronic highway" - by which various entities within the healthcare system could send and receive information efficiently. Providers and payers could be linked via clearinghouses, which would receive data from one organization and send it out to another. Or, they could be linked directly, through new and existing fiber optic cable lines and electronic data interchange translators.

D. THE IMPACT OF THE HFMA LEGISLATIVE PROPOSAL ON HEALTHCARE ADMINISTRATION

1. Potential Savings Areas

The HFMA proposal will have a noticeable impact on several specific administrative tasks and functions. Table 2 below exhibits areas of probable savings under the legislation for both providers and payers:

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14 The Workgroup for Electronic Data Interchange (WEDI), Report to Secretary of U.S. Department of Health and Human Services, July 1992: 4.

15 Federal Register 15 January 1993: 4705.

Table 2
Savings Areas

Category	Physician	Hospital	Insurer
Claim submission	✓	✓	
Claims processing			✓
Claims denial and adjudication	✓	✓	✓
Coordination of benefits			✓
Patient accounting	✓	✓	
Credit/collections/billing	✓	✓	
Enrollment			✓
Eligibility determination	✓	✓	✓

Automation should significantly impact claims submission, processing, and adjudication. Because many claims activities are, to some degree, already conducted electronically, savings would result from automating the remaining claims functions and standardizing transmittal processes for those already automated. Under the HFMA proposal, providers would enter information about a patient's treatment into a computer and submit the relevant claim information to payers. Payers, in turn, would receive the claim electronically, process it, and determine payment. Administrative savings would be achieved through the capability to transmit, receive, and process thousands of claims instantaneously. Standardized data transmission formats would eliminate the need for payers and providers to invest in multiple computer systems and programs, as well as additional human resources, for the sole purpose of translating data into readable form.

Most importantly, perhaps, automated claims processing would save money by reducing the incidence of errors and rejected claims. It is estimated that one of three paper claims is rejected by payers and must be re-submitted, while only 1% of electronic claims are rejected.[16] Errors can be reduced through electronic verification and correction procedures at both the provider and payer levels.

Another area of probable savings, the coordination of benefits, is closely related to claims processing. As stated earlier, the U.S. healthcare system is characterized by multiple-billing schemes, whereby claims for individual services are sent to several payers. The HFMA proposal would automate the process of sending claims to payers in the proper sequence. The "primary payer" would be able to send claim information to the "secondary payer", and so on. Money is saved by relying on an expert computer system, rather than human resources, to determine which payer should receive what portion of the claim.

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16 Gardner, Elizabeth and Judith Nemes, "Hospital Cashing in on Cleaned-Up Claims Processing," Modern Healthcare 26 March 1990: 24.

Implementation of the HFMA proposal might also engender savings in financial applications such as patient accounting, billing, and credit and collection functions.[17] Standard formats and official data sets would allow for the electronic transmission and receipt of data on billing, remittance, and payment. Billing and accounting information would accrue in a database, permitting notification of providers concerning payment amounts, verification of payment, and automatic funds transfer. Savings would be achieved through standardization of formats and minimization of paper and postal transactions.

Other probable areas of administrative savings include eligibility and enrollment functions. Under the HFMA proposal, payers would maintain automated membership information, and would be able to transfer individuals who changed carriers. Providers could access eligibility databases in order to determine an individual's benefit coverage for a given procedure. The simplicity and expediency of fully automated enrollment and eligibility functions would save time and money.

It should be noted that much of the literature that addresses administrative savings assumes that functions such as hospital billing and multi-payer reimbursement will be eliminated through implementation of a single-payer system. Automating, standardizing, and simplifying processes of communication under the HFMA proposal, on the other hand, would not remove some of these significant cost-producing features of the current U.S. system, in that even under healthcare reform it is likely that healthcare information at the individual level will be required for system accountability. Hospital billing and multi-payer reimbursement would be made more efficient, but would not be eliminated. Other administrative costs spawned by the tendency among small firms to switch insurers frequently and the prevalence of selective contracting and provider discounts may not be affected by automation at all. For these reasons, we would not expect administrative savings under the HFMA proposal to be as large as those cited in the literature for Canadian style single-payer reform.

2. Costs of Implementation

While the Healthcare Administrative Simplification and Uniformity Act, as proposed by HFMA, targets certain administrative tasks for cost savings, implementation of the legislation itself likely will require substantial expenditures. The process of getting individuals and organizations to communicate in new ways is complex and time-intensive. Any effort to estimate administrative savings effected by automation must factor in the additional costs of administering new mechanisms for interaction.

The cost of the technology and associated infrastructure would be significant. The HFMA proposal envisions a system in which all providers have access to computers, and all computers are connected through comprehensive networks or clearinghouses. Added to the costs of setting up and maintaining this configuration are the costs of developing and updating standard data formats for information exchange. Also, many workers would have to be trained in basic computer literacy. Another possible downside of automated systems is misuse. Expert systems could be developed to monitor submitted claims patterns. Finally, there is the need to assess patient confidentiality laws as large medical databases are compiled.

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17 Expected savings based on similar proposals in the WEDI report.

E. SAVINGS AND COST ESTIMATES

1. Gross Administrative Savings

Several recent studies have attempted to estimate the effects of data automation on administrative costs. All project savings, but the actual figures vary due to disparate assumptions, discrepancies in what is being measured, and differences in underlying statistics. Four savings estimates - conducted by Clinton transition team members[18], the Workgroup for Electronic Data Interchange (WEDI)[19], the Health Care Financing Administration (HCFA)[20], and Lewin-VHI[21] - are summarized in Table 3.

The range put forth by the Workgroup for Electronic Data Interchange is a variation on the HCFA numbers, as HCFA based its estimate on electronic initiatives proposed by WEDI. We use the HCFA figure and the Lewin-VHI figure as our points of comparison.

a. Estimate Using HCFA Unit Savings Assumptions: $9.4 Billion[22]

The HCFA estimate is an agglomeration of savings for several different administrative activities, including enrollment, eligibility, claims processing, claims inquiries, payment and remittance, and clinical information. Savings are calculated by first estimating the number of claims or transactions associated with each activity, and then computing the projected savings which automation will engender for a given claim or transaction.

HCFA identifies claims processing as the function with the greatest savings potential. The underlying assumptions are as follows: automation of claims processing functions will allow payers and providers to each save 50 cents per claim on a total of 3 billion paper (non automated) claims. In addition, the standardization of data formats will allow providers to save an extra 75 cents per claim on these 3 billion paper claims, plus 75 cents per claim on the 1 billion claims that are already automated.

In summary, then, the HCFA estimate assumes that automation and standardization of claims processing functions will save $1.25 per claim on the provider side (75 cents plus 50 cents) and 50 cents per claim on the payer side. It is assumed that there are 4 billion claims in the system, 1 billion of which are already automated. It is crucial to note at this point that these claims are defined as single events, or individual line items on a medical bill. In other words, each visit, test, or procedure performed by a provider is counted as a separate "claim".

Aside from claims processing and standardization, HCFA estimates savings for the following categories: $82 million for automation of claims inquiries, $439 million for automation of enrollment and eligibility functions, $1.3 billion for electronic payment and remittance, and $1.6 billion for automation of medical records.

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18 Unofficial transition team document.
19 WEDI: 25.
20 Undated internal HCFA document.
21 Lewin-VHI, staff working document.
22 Lewin-VHI calculations using HCFA unit savings estimates.

Table 3

Administrative Savings Estimates

(1993 Dollars)

Source	Savings Estimate	Scope of Estimate	Underlying Statistics/Assumptions
Unofficial Transition Team Document (unpublished)	$1-$2 billion	Savings based on automation of claims processing, national level service data, individual medical records.	Within four years, 90-95% of billing and some diagnostic data could be captured in a central database.
HCFA (undated HCFA documents)	$9.4 billion	Savings based on automation of enrollment, eligibility, claims processing, claims inquiries, payment and remittance, and clinical information.	*Claim is defined as a line item.* <u>Claims processing:</u> payers and providers each save 50 cents per claim on an estimated 3 billion paper claims <u>Eligibility:</u> $1.40 savings for each of 75 million transactions <u>Standardization:</u> providers save 75 cents per claim on 4 billion claims
WEDI Report	$4-$10 billion	Savings based on automation of enrollment, eligibility, claim submission and processing, payment and remittance, and clinical data.	Savings based on full implementation, which "can be accomplished this decade".
Lewin-VHI	$1.9 billion	Savings based on automation of claims processing only.	*Claim is defined as a medical bill.* <u>Claims processing:</u> providers save $1.30 and payers save 60 cents on each of 1 billion claims.

b. Lewin-VHI Estimate: $1.9 Billion

Lewin-VHI estimates savings for claims processing and standardization only. The Lewin-VHI number is computed using the same fundamental methodology as the HCFA estimate. Savings are calculated by first estimating the number of claims or transactions associated with each activity, and then computing the projected savings which automation will engender for a given claim or transaction. It is assumed that, with automation, providers will save $1.30 and payers will save 60 cents on each of one billion claims.

Adding the Lewin-VHI savings figures of $1.30 per claim for providers and 60 cents per claim for payers yields $1.90 per claim in total savings. While this figure resembles the HCFA savings estimate of $1.75 per claim ($1.25 provider plus 50 cents payer), the discrepancy in estimated number of claims is large, resulting from the different ways in which the two organizations define a claim. As stated above, HCFA and WEDI define a claim as a single line item on a medical bill. Lewin-VHI, on the other hand, counts the entire medical bill as a single claim. In other words, a visit to a provider and all associated tests and procedures would be counted as one claim under the Lewin-VHI estimate. Lewin-VHI estimates that there were approximately one billion "claims" in 1991. This estimate was derived from National Medical Care Utilization and Expenditure Survey (NMCUES) data. Estimates of savings per claim were obtained from industry sources, including the Medical Group Management Association (MGMA).

c. Computing a Range of Savings

The one billion versus four billion claims discrepancy evolves purely from definitional differences. It is reasonable to assume that a given medical bill contains four line items (e.g. one visit and three tests). Therefore, four billion line items are roughly equivalent to one billion medical bills. Furthermore, other attempts to estimate the number of claims and line items in the healthcare system are in accord with the one billion/four billion figures put forth by Lewin-VHI and HCFA.[23]

The different definitions of a claim, however, yield a large range in estimates of savings to be achieved through the automation of claims processing functions. Lewin-VHI estimates $1.90 in savings per claim form. HCFA estimates $1.75 in savings per line item for paper claims and 75 cents per line for currently automated claims. Using our estimate of four line items per claim form, the HCFA figure implies that automation will yield savings of up to $7 per paper claim form and $3 per claim form for currently automated claims. Various sources have computed savings estimates of $1.50-$2 per claim form, thus positioning themselves on the Lewin-VHI end of the range.[24] Other industry sources cite figures of $5 in savings per claim form.[25] In the interest of representing varying assumptions, we report savings for claims processing as a range of possible values. We will use the Lewin-VHI figure to compute the lower bound of our range, and the $3 (already automated)/$5 (currently paper) savings figures to compute the upper end. We believe that the discrepancy between the

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23 Faulkner and Gray, "1993 Medical Payments Data Book," Automated Medical Payments News, 8 February 1993.
24 Conversations with the Medical Group Management Association.
25 Personal conversation with Doug Willis, New York Single-Payer Demonstration Program, 19 April 1993; Conversations with Faulkner and Gray staff, 15 April 1993.

lower and higher savings figures arises from different assumptions about the efficacy of automation in reducing claims errors.

Table 4
Calculation of Total Savings from Automation and Standardization

CATEGORY	CALCULATION	SAVINGS ESTIMATE
Claims submission / processing / standardization	Lower bound: $1.90 savings per claim form x 1 billion claims forms = Upper bound: $5 savings per claim form x 750 million paper claims + $3 savings per claim form x 250 million currently automated claims =	$1.9 billion $4.5 billion
Claims inquiries	Assume savings equal to HCFA estimate*	$82 million
Enrollment and eligibility	$1.40 savings per transaction x 75 million transactions =	$105 million
Payment and remittance	Assume savings equal to HCFA estimate*	$1.3 billion

*HCFA estimates for these categories are one-half of WEDI estimates.

RANGE OF TOTAL GROSS SAVINGS: $3.4 BILLION - $6.0 BILLION

The savings range, expressed above, represents the sum of all savings categories. This is not a range of estimates from the literature, but rather our range as computed from the calculations and assumptions expressed in Table 4. The lower bound of the range is associated with the Lewin-VHI estimate for claims processing savings, while the upper bound accounts for our synthesis of upper bound estimates.

2. Costs of Implementation

HCFA appraises annual investment costs and network operating costs for administrative automation at $767 million for 1993. This figure includes the cost of setting up and operating numerous community-based systems throughout the country, as well as the projected Federal spending necessary to connect community networks to one another.

3. Net Savings

Subtracting the costs of implementation from savings figures, we are left with a range of $2.6 to $5.2 billion (1993) in net savings resulting from the automation of healthcare administrative functions. As derived above, our 1991 study synthesis estimate of administrative costs is $125.6 billion. Inflated to 1993 dollars, this estimate becomes $132.5

billion. Therefore, we project that automation will save 2.0 percent to 3.9 percent of total healthcare administrative costs.

RANGE OF TOTAL NET SAVINGS: $2.6 BILLION - $5.2 BILLION

F. CONCLUSIONS

1. Summary of Cost and Savings Estimates

Our study synthesis estimate of 1991 administrative costs is $125.6 billion, or 17 percent of total health expenditures. These costs could be reduced by implementing the Healthcare Administrative Simplification and Uniformity Act of 1993, as proposed by HFMA. Automation will expedite and simplify a select set of administrative functions - claims submission and processing, payment and accounting, enrollment and eligibility - rather than radically alter the manner in which health care is administered. We estimate that automation will produce a net savings of $2.6 to $5.2 billion, or 2.0 percent to 3.9 percent of total administrative costs.

2. Non administrative Benefits

While the proposed Healthcare Administrative Simplification and Uniformity Act would yield administrative savings, it is also important to understand that many non administrative benefits would emerge if automation were extended to clinical systems. Automation on the scale of the HFMA proposal would provide healthcare managers with the data they need to be effective. Currently, such data representing private sector transactions are lacking, as individual employers' and insurers' databases are usually too small to enable reliable comparisons of charges and episodes of care, and aggregating non uniform data is a nearly impossible task.[26] HCFA projects that the automation and aggregation of clinical data alone could save nearly $18 billion in 1993 by reducing the incidence of diagnostic tests, reducing length of stay, making hospital staff more efficient, and improving the overall quality of care.[27]

The availability of large-scale, uniform, service-level databases would be an invaluable tool for appraising the performance of healthcare organizations and the efficacy of different treatment options. Standardization reduces error and permits comparison. The implications of automation for healthcare reform are clear: reliable data would foster accurate comparisons of fee-for-service and managed care, evaluations of private and public sector benefit plans, and setting of budgets. In essence, electronic highways and automated data transmission are a necessary component of any attempt at health reform.

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26 Etheredge, Lynn and Stanley Jones, "Managing a Pluralist Health System," Health Affairs, Winter 1991: 96.
27 Undated internal HCFA document.

Chairman STARK. Mr. Houtz.

STATEMENT OF JIM H. HOUTZ, PRESIDENT, ASSOCIATION FOR ELECTRONIC HEALTH CARE TRANSACTIONS, AND CHAIRMAN AND CHIEF EXECUTIVE OFFICER, CYDATA SYSTEMS, SCOTTSDALE, ARIZ.

Mr. HOUTZ. Good afternoon.

Mr. Chairman, members of the subcommittee, my name is Jim Houtz, and I am here representing the Association for Electronic Health Care Transactions, AFEHCT. It is a membership association of companies sand suppliers engaged in health care electronic data interchange—or EDI.

AFEHCT companies operate the clearinghouses and the value-added networks. They are the companies that are developing the software and communication technology to allow communications between providers, payers and employers. They are the companies that are engaged in building the electronic superhighway.

AFEHCT was formed late last year in response to the growing recognition being given to the need for administrative simplification. The member companies of AFEHCT have adopted as a mission statement the goal of promoting innovation, cooperation and open competition within the health care EDI industry, improving the quality and effectiveness of health care and achieving administrative simplification and cost savings in the delivery of health care services.

AFEHCT strongly supports the development and implementation of industry standards, specifically ANSI X.12. In fact, we support most of but not all H.R. 200 which we feel is a good start. Further, the association is calling for compliance with industry performance and protocol guidelines.

The electronic health care transaction industry is less than 10 years old, yet in that short time this infant industry has put together a communications network that will process over 700 million health care transactions electronically in 1993. Admittedly, there remains significant areas for improvement, but if you remove some of the obstacles and impediments, the industry has proven itself capable of resolving the administrative simplification challenge.

The rest of my statement is there for your review, and I will summarize the rest of it.

WEDI and other groups have already called for Federal legislation of the ANSI standards, including the data content, the privacy and the confidentiality statements. We strongly agree with that position. We feel if the end product is either a government-run system or a system dictated by a government agency through monopoly contracting, then the private sector will question its direction in continuing to invest in these systems.

AFEHCT members have already invested hundreds of millions of dollars in their systems and in their software. We encourage the Federal Government not to preempt the private sector but rather to build a system which will encourage competition and continued investment. In this process, the Nation's health care system will benefit not only from the extent of added services but from the competitive marketplace.

Our guiding principles are very simple. We feel the system must be universal and utilize standardized electronic processing and communication protocols. The system must be open, permitting all vendors and suppliers who are capable of meeting the standards to compete freely in serving payers, patients and providers.

We want to thank the subcommittee for this opportunity to be here today, and I commend you on your efforts to move ahead with administrative simplification in an expeditious manner. Thank you.

Chairman STARK. Thank you, Mr. Houtz.

[The prepared statement follows:]

Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
May 25, 1993

Testimony on Behalf of the
Association for Electronic Health Care Transactions (AFEHCT)

Mr. Chairman, Members of the Subcommittee, my name is Jim H. Houtz, and I am here representing the Association for Electronic Health Care Transactions (AFEHCT), a membership association of companies and suppliers engaged in health care electronic data interchange -- EDI.

- AFEHCT companies operate the clearinghouses;
- they are the companies that are developing the software and communication technology;
- they are the companies that are engaged in building the electronic superhighway on which vital health care transactional data will travel.

AFEHCT was formed late last year in response to the growing recognition being given to the need for *administrative simplification* in the health care delivery system. The member companies of AFEHCT have adopted as their Mission Statement, a goal of

- promoting innovation, cooperation and open competition within the health care EDI industry,
- improving the quality and effectiveness of health care, and
- achieving even greater *administrative simplification* and cost savings in the delivery of health care services.

Toward these ends, AFEHCT strongly supports the development and implementation of industry standards, including those standards being developed by the X.12 Committee of the American National Standards Institute. Further, the Association is calling for compliance with industry performance and protocol guidelines and hopes to play an active role in setting these protocols to meet the needs of the health care industry.

The electronic health care transaction industry is less than 10 years old. Yet, in that short time -- without government intervention . . . without tax incentives and regulations . . . and without mandated standard communication linkages and common processing systems -- this nascent industry has put together a communications network that will process over 700 million health care transactions electronically in 1993. Admittedly, there remain significant areas for improvement, but . . . . remove some of the impediments and the roadblocks and the industry has proven itself capable of resolving the administrative simplification conundrum.

How can these goals be accomplished? AFEHCT suggests --

ANSI Standards -- AFEHCT supports not only the adoption of ANSI X.12 Committee standards, but also supports efforts to make uniform the application of these standards at all points along the electronic highway.

Universal Identification -- If the electronic highway is to work, it is critical that all players, purchasers, patients, payers and providers, be capable of being uniquely identified. AFEHCT supports and calls for a system of unique identifiers, defined by the Secretary and supported by all industry participants.

Electronic Cards -- This issue must be studied before application as there are many technical and practical difficulties that will be encountered. AFEHCT suggests that such things as "electronically-encoded" swipe cards may be useful in automating the eligibility and front-end data entry process, but that more elaborate "smart cards" need to be closely reviewed before any commitment on implementation can be made.

Eligibility and Benefit Information -- All industry players must provide open access and EDI network processors must foster and promote interconnectivity for EDI transactions. The industry has defined standards for the required technical protocols, data content, and timeliness of such transactions. Confidentiality and security from unauthorized use need to be assured.

Dynamic Software -- The system must encourage and promote the development of dynamic, evolving software and avoid stagnancy through unsupported public domain software.

State Quill Pen Laws -- These and other barriers to electronic processing must be pre-empted and incentives established for the private sector to make even greater inroads into automating traditional paper-processing of health care and medical records. Electronic signatures using the unique identifiers must be permitted.

Industry Guidelines and Standard Trading Partner Agreements -- To encourage widespread implementation of health care EDI, many purchasers need additional guidance in understanding, assistance in defining and confidence in the selection of EDI systems, networks and vendors with whom they choose to participate. Established industry guidelines and standard trading partner agreements will begin to lay the foundation for an "apples to apples" comparison of EDI vendor networks.

AFEHCT recommends:

The industry be given the opportunity to develop standardized trading partner agreements to govern relationships both within and between EDI vendor networks, telecommunication systems and which will establish a high level of standards with respect to the quality, integrity and security of competing but compatible systems.

Why do we make this recommendation?

- WEDI and other groups have already called for Federal regulation of the ANSI standards, the data content, the privacy and confidentiality standards. Further regulation would be redundant and expensive and would undermine competition in the marketplace.

- The cost of a formal accreditation program would be very high and would not necessarily assure either quality or standards.

- Trading partner agreements have worked in other industries and are more flexible, are readily adjustable to changing needs and circumstances and they allow market forces to function without impeding new technology and price competition.

Paying For It

If the end product is either a government-run system, or a system dictated by a government agency through monopoly contracting, then the private sector will be unwilling to continue its investment in health care EDI and the cost will have to be borne by the program. AFEHCT members have already invested Hundreds of Millions of Dollars in their systems and in their software. They stand ready to continue making this investment in newer and even more advanced technology. We encourage the federal government not to pre-empt the private sector, but rather to build a system which will encourage competition and continued investment. In this process, the nation's health care system will benefit not only from expanded services but also from the competitive marketplace.

Guiding Principles

While individual members of AFEHCT will have different opinions as to the exact structure and format of an administrative simplification network -- every member of our Association feels that whatever system is developed that system must be open and competitive. Vendors, suppliers and communication networks capable of meeting the standards should be allowed to openly compete -- we believe:

System must be UNIVERSAL and utilize STANDARDIZED electronic processing and communication protocols.

- It will use a single national system of standards for processing of claims, including a universal billing form, common eligibility (*i.e.,* "swipe" card) inquiry and "coordination of benefit" standards, common managed care authorization and pre-certification protocols, uniform claims adjudication processes, simplified claims tracking and payment review procedures, including electronic funds transfer.

- It will incorporate common audit review and utilization control mechanisms and standardized record-keeping coupled with medical records privacy controls.

- It will enable program managers to see on a real-time basis actual trends in the delivery of care and to identify cost efficiencies as well as inefficient delivery capabilities.

System must be OPEN, permitting all vendors and suppliers who are capable of meeting the STANDARDS of the UNIVERSAL system to freely COMPETE in serving purchasers, patients, providers and payers.

- Present system of closed competition and federally-supervised monopolies in administration of government health care programs has stifled innovation and has not encouraged the maximum use of technology.

- Suppliers of technology and services will compete on the open market not only for price but for "bells and whistles," technology advances and improved systems.

We want to thank the Subcommittee for this opportunity to be here today and participate in this very important process. The effort to build on what the health care industry already has underway in the area of administrative simplification is critical to the ultimate success of any national health care reform proposal. We look forward to the opportunity to continue to work with the Subcommittee and its staff in defining the need and in implementing solutions. We encourage you in this action and we stand ready to re-double our effort in an open an competitive environment.

ASSOCIATION FOR ELECTRONIC HEALTH CARE TRANSACTIONS
MEMBER COMPANIES

Advacare, Inc.
Advantis
Ameritech Health Connections, Inc.
Blue Cross-Blue Shield of Georgia
Blue Cross-Blue Shield of Maine
Blue Cross of California
CIS Technologies, Inc.
Context Software Systems, Inc.
Cooperative Health Network (CHN)
CSA Provider Services
CSC Healthcare Systems
CyData Systems
Electronic Data Systems (EDS)
Ethix Corporation
First Health Services Corporation
General Computer Corp.
GTE Health Systems
Healthcare Interchange, Inc.
Health Information Technologies
Health Management Systems, Inc.
Integrated Systems Solutions Corp.
IVANS
Med E America, Inc.
Medical Review Systems
Mediquest, Inc.
Med-Systems Management, Inc.
Millenium
National Data Corporation (NDC)
National Electronic Information Corporation
Orion Computer Systems, Inc.
PhyMed Services International, Inc.
Physician Practice Management
United Healthcare
Verifone
Wellmark

Chairman STARK. Ms. Ryan.

STATEMENT OF LINDA K. RYAN, DIRECTOR, NEW YORK HEALTH CARE INFORMATION CLEARINGHOUSE PROGRAM, NEW YORK STATE DEPARTMENT OF HEALTH

Ms. RYAN. Good afternoon, Mr. Chairman and Mrs. Johnson. I am pleased to testify today on behalf of the New York State Department of Health and to tell you about our efforts to streamline the administration of health care.

The New York Health Care Information Clearinghouse Program, which was formally known as the Single-Payer Demonstration Program, was developed by the New York State Department of Health with support from the Robert Wood Johnson Foundation. Its goal is to introduce technologies that can operate in a multiple-payer system to mimic the efficiency of a single-payer.

The Health Care Information Clearinghouse Program is divided into several phases. Phase one involved the development and implementation of an electronic claims submission system for all major payers in New York. This system established an electronic network between providers and payers for the transfer of claim data.

The electronic flow of claim data results in prompter payment and reduces days in accounts receivable. In fact, while denials for coverability continue, acceptance for claims as accurate and complete is as high as 99 percent. Payers also realize decreased administrative expense associated with reviewing and returning inaccurate and incomplete claims. They estimate reductions of $3 to $8 per claim when an electronic claim replaces a paper claim.

Some 25 of our 27 participating hospitals are now operational, with the remaining 2 to be placed on the network this summer. We also plan to add clinics and physicians in the next quarter.

Phase two of the Health Care Information Clearinghouse Program consists of the development of several system enhancements. The first enhancement involved development of a networked, integrated point-of-service eligibility file. Thirteen sites are now operational. It is anticipated that the integrated point-of-service eligibility file will be operational in all sites this summer.

The integrated eligibility file forms the basis for the development of an automated coordination of benefits system which will automatically assign financial responsibility to a patient's various resources, thus maximizing the patient's insurance benefits and appropriately assigning responsibility. As a concurrent effort, the Health Care Information Clearinghouse Program is working with vendors and specialists in cash flow management to develop the capability for electronic funds transfer.

Phase three of the program, which is just beginning, involves voluntary statewide expansion and will include new providers and payers.

It is important to note here that we have taken an approach that builds on existing systems and low-cost technology. Transfer of information to the clearinghouse is done through personal computers and telephone lines, interfaced with existing hospital mainframe systems, eliminating the need for significant new investment. The eligibility system is a network of existing files at the payer sites.

Insurers retain and maintain their own files. Redundant files which are costly to build and maintain are eliminated. The network approach offers the provider a single computer and a single process which can access several files to transmit claims and confirm eligibility on a real time basis.

We have recently proposed legislation which authorizes expansion of the Health Care Information Clearinghouse Program statewide and provides for the ongoing operation of the statewide clearinghouse at the conclusion of our demonstration.

The New York State Department of Health will continue to provide program management by coordinating participation of providers and payers. We will also continue our efforts with insurers to standardize processes and protocols and identify new opportunities for efficiency.

The development of the electronic network of providers and payers will not only facilitate the flow of information for decision making but does so at a reduced administrative cost. The patient will benefit from this system by coordination of his insurance and reduced direct patient billing. The resultant improved patient-provider relationship will allow for the focus on health care delivery, not administrative paperwork.

Finally, the network permits all parties to share information for informed decision making about resource consumption and financial responsibilities. Most importantly, security and confidentiality of information can be strengthened through the use of technology. The opportunity for a misplaced letter or form containing sensitive patient information is eliminated.

We think the Health Care Information Clearinghouse Program demonstrates that government working in partnership with providers and private industry can create the electronic infrastructure and design the tools that are needed to support an efficient and affordable system that is capable of providing health care to everyone.

Thank you.

Chairman STARK. Thank you very much, Ms. Ryan.

[The prepared statement follows:]

TESTIMONY OF LINDA K. RYAN
NEW YORK HEALTH CARE INFORMATION CLEARINGHOUSE PROGRAM

Mr. Chairman and members of the Subcommittee, I am pleased to testify today on behalf of the New York State Department of Health and to tell you about our efforts to streamline the administration of health care.

The New York Health Care Information Clearinghouse Program, formerly known as the Single Payer Demonstration Program, was developed by the New York State Department of Health with support from The Robert Wood Johnson Foundation. Its goal is to introduce technologies that can operate in a multiple payer system to mimic the efficiency of a single payer.

BACKGROUND

The current system of billing and payment is composed of a series of payer specific and provider specific data sets for claims processing. The varying requirements in information and formatting, as well as the variation in attachments and billing protocols, has led to an 18% of hospital costs. The complexity and difficulty in collection has been reflected in an increase in bad debt for acute care from 3.7% of gross revenues in the fourth quarter of 1990 to 4.3% in the first quarter of 1991.

Central to the Health Care Information Clearinghouse Program is the use of a claims clearinghouse to transmit electronic claims, eligibility and payment information. The program is designed around the basic principles for administrative efficiency and cost savings, reduction in manual intervention, elimination of duplication and standardization of administrative processes and protocols. We are working with providers to improve administrative efficiency by coordinating, automating and standardizing claims processing, billing and payment systems. The Program began in November, 1990 and is being conducted over a four year period for participating hospitals, free-standing clinics and physicians.

THE DEMONSTRATION

Participation of twenty-seven facilities in New York State has been secured. These facilities represent over 12,000 beds and $3.3 billion in annual operating revenues. This translates to about 17% of the total beds and over 19% of operating revenues statewide. Days in Accounts Receivable for these facilities range from 41-160 on the inpatient side to 34-232 on the outpatient side. An important priority for the Health Care Information Clearinghouse Program will be to expand this baseline of hospital performance and to measure the impact of each system enhancement of the Program on that performance.

The New York State Department of Health is assuming the responsibility for coordinating provider and payer participation. In addition, the Program has assumed responsibility for securing vendor services for computer support. In the summer of 1990, we signed contracts with Wellmark, Inc. of Westlake Village, California and CIS Technologies, Inc. of Tulsa, Oklahoma to act as our clearinghouses and provide systems support.

The Health Care Information Clearinghouse Program is divided into several phases. Phase 1 involved the development and implementation of an electronic clean claims submission system for all payers. This system established an electronic network between providers and payers for the transfer of claim data. Redundancy is eliminated by the transfer of information directly from the hospital information system to a PC at the hospital site

for payer-specific editing and transfer. Further economies are realized by the reduction of paper processes such as mailing, logging and correction. Prompted error correction speeds the transfer of complete and accurate information through the clearinghouse to the payer resulting in fewer claim rejections and denials. While denials for coverability continue, acceptance of claims as accurate and complete is as high as 99%. In addition, the network facilitates the efficient transfer of management data to monitor performance of the patient accounting function and cash flow.

The electronic flow of clean claim data will reduce days in accounts receivable. Payers, similarly, will realize decreased administrative expense associated with reviewing and returning inaccurate and incomplete claims. In fact, payers estimate reductions of from $3.00-$8.00 per claim when an electronic claim replaces a paper claim. Further, online inquiry eliminates frequent provider phone calls regarding claim status. Payers, in turn, can use the network to request additional information for adjudication decisions. The capability for electronic remittance advice has been developed as a part of this system to permit the effective management of accounts receivable. The capability for transfer of required government reporting through the electronic network has also been established.

The first hospital system for electronic claims processing was installed in the fall of 1991 sending claims across the network to all major payers by November, 1991. Twenty-five hospitals are now fully operational, with the remaining two to be placed on the network by this summer. All claims from the provider may be transmitted including inpatient, outpatient, ambulatory services and related services such as lab, x-ray or hospital based physician claims. Currently, we are working with free-standing clinics and physicians to put them on the network as well.

Phase 2 of the Health Care Information Clearinghouse Program consists of the development of several system enhancements. The first enhancement involved development of a networked integrated point-of-service eligibility file. This subsystem permits the provider to determine enrollment in one or several insurance plans, at the time of service. Information about co-payments, deductible status and utilization controls can be transmitted. It is anticipated that bad debt can be reduced by the ability to confirm eligibility status for all payers. The patient whose benefits are no longer in effect can be counselled and a payment program developed at the time of service. This reduces the need for dunning notices and collection agencies. Several sites are now operational and it is anticipated that the integrated point-of-service eligibility system will be operational in all sites this summer.

It is important to note here that we have taken an approach that builds on existing systems and low cost technology. Transfer of information to the clearinghouse is done through personal computers and telephone lines interfaced with the existing hospital mainframe, eliminating the need for significant new investment. The eligibility system is a network of existing files at the payer site. Insurers retain and maintain their own files. Redundant files which are costly to build and maintain are eliminated. The network approach offers the provider a single computer and a single process which can access several files to confirm eligibility on a real-time basis.

The integrated eligibility file forms the basis for the development of an automated coordination of benefits subsystem. This subsystem will automatically assign financial responsibility to a patient's various resources, thus maximizing the patient's insurance benefits and appropriately assigning responsibility. Furthermore, the automated system eliminates the need to develop a new bill for each payment source with a new opportunity for error. Finally, the task of coordinating benefits is done by the computer rather than the patient. This capability has been developed and is about to enter testing. It is anticipated that it will be operational by November, 1993.

As a concurrent effort, the Health Care Information Clearinghouse Program is working with its vendors and specialists in cash flow management to develop the capability for electronic funds transfer. The requirements, functionality and cost benefit of electronic funds transfer will be explored with participating payers and providers. This capability will be implemented at selected sites in late 1993.

Standardization is an important part of administrative efficiency. In the current environment, providers often organize billing and payment around payers. They must keep track of the varying information requirements, codes and formats. The promotion of a limited number of uniform claim forms has reduced the confusion on the submission side. However, standard formats for eligibility and payment information are only now being introduced. The Health Care Information Clearinghouse Program is working with the payers to identify opportunities to reduce variation, including the need for attachments and to promote the use of ANSI standards as they become available.

Phase 3 of the Demonstration involves voluntary statewide expansion and will include new providers and payers. The Department of Health will provide contract management services to assure smooth implementation and operations. Part of the effort to expand the Program will be to include employer and benefit plans. Finally, the Department of Health, providers, and payers will continue to work jointly to define system enhancements.

Statewide Electronic Claims Clearinghouse

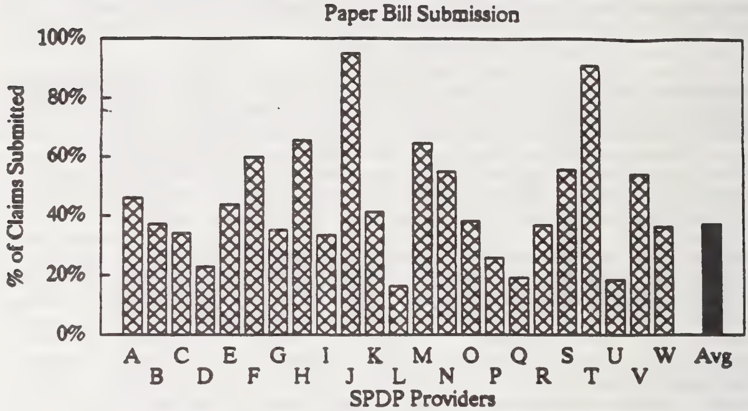
We have recently proposed legislation which authorizes expansion of the Health Care Information Clearinghouse Program statewide and provides for the ongoing operation of the statewide electronic claims clearinghouse at the conclusion of the Demonstration. It provides standards of performance for clearinghouse vendors to ensure that the maximal benefits of administrative efficiency are achieved. The full range of services described in the demonstration are included.

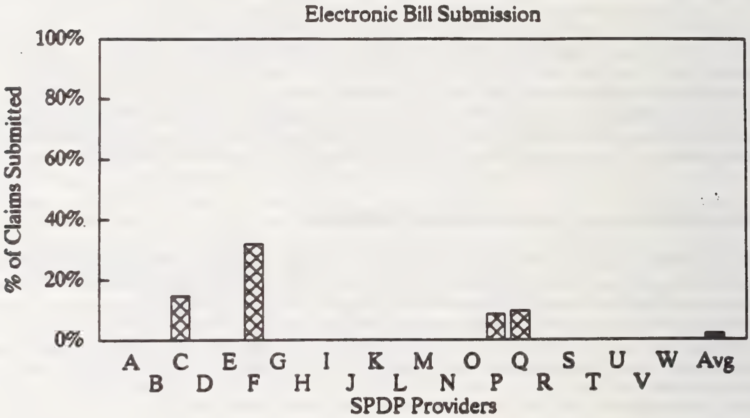
The New York State Department of Health will continue to provide program management by coordinating participation of providers and payers. We will also continue our efforts with insurers to standardize processes and protocols and identify new opportunities for efficiency.

Expected Outcomes

By requiring that all claims to all payers be processed through a clearinghouse, the Statewide Electronic Claims Clearinghouse intends to demonstrate additional efficiencies, cost savings, and information enhancement for all parties - government, providers, payers and patients.

Most providers that use a mix of manual and payer specific electronic claims submission generate between 25-50 bills per day per billing clerk. In New York State, providers rely heavily on paper billing. Electronic submission is limited.





Following full implementation of the Electronic Claims Clearinghouse, productivity should increase to an average of 100 bills per day per billing clerk, and often much higher. Information will be more accurate and reliable. With cleaner claims being transmitted from the start, and increased productivity, the followup process can begin much earlier. This ultimately leads to an increase in revenue and reduction in bad debt.

Specific cost benefit projections were developed using experience and savings models applied to baseline data. It was estimated that accounts receivable for the Program would drop an average of 21 days for this group of participating providers. In addition, given the current staffing levels, it was estimated that hospitals could reduce billing staff an average of twenty-five percent. Miscellaneous savings accruing from reduction in mailing and payer specific billing services were also estimated. Finally, reduction in bad debt through earlier, more focused pursuit of third party billing and patient collection was estimated. While active receivables programs have estimated bad debt reductions as great as 25%, a more conservative estimate of 10% was applied to allow for the greater than average proportion of Medicaid/Medicare billings. Cost savings estimates for the Program and Statewide Projections are given below.

PROJECTED ANNUAL COST/BENEFIT

	Demonstration Providers	Statewide Projections
Costs		
Operations	$ 5,577,100	$ 32,443,600
Benefits		
Staff Reductions	$ 6,054,000	$ 34,953,100
A/R Improvement (@ 5% int. rate)	$ 9,796,200	$ 47,759,000
Miscellaneous Savings	$ 255,500	$ 1,486,300
Bad Debt Reduction	$29,828,900	$155,953,800
Total Recurring Benefit	$45,934,600	$240,152,200
Net Annual Benefit	$40,357,400	$207,708,600

CONCLUSION

Health care is truly a public/private partnership in the United States. With Medicaid and Medicare paying for the majority of all health care services, and employers and patients paying the rest, it is in our collective best interest to rationalize the administration of health care and generate the data that will allow all segments of the community to understand and use health care services wisely.

The development of the electronic network of providers and payers will not only facilitate the flow of information for decision making, but does so at a reduced administrative cost for all parties. The patient will benefit from the system by coordination of his insurance with reduced direct patient billing. The resultant improved patient-provider relationship will allow for the focus on health care delivery not administrative paperwork. Finally, the network permits all parties to share information for informed decision making about resource consumption and financial responsibilities.

The creation of an electronic infrastructure supports the development of efficiency in communication among providers, payers and government. Applications for sharing of clinical information which permit timely transfer can be implemented. For example, the physician can send needed pre-admission data to the hospital. In turn, a hospital can transfer an aftercare plan to the physician. Timely and accurate information will improve quality and coordination of care. At this time, we are exploring

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the addition of clinical information to the network with support from The John A. Hartford Foundation under their Community Health Management Information System initiative.

Most importantly, security and confidentiality of information can be strengthened through the use of technology. The opportunity for a misplaced letter or form containing sensitive patient information is eliminated. Access can be restricted through both hardware and software applications. Information can be encrypted or masked to permit use only in the absence of individual identifiers.

The Health Care Information Clearinghouse Program demonstrates that government, working in partnership with providers and private industry, can create the electronic infrastructure and design tools that are needed to construct an efficient and affordable system that is capable of providing health care to everyone.

Chairman STARK. Mr. Spears.

STATEMENT OF JEFFREY B. SPEARS, MANAGER, GOVERNMENT AND INDUSTRY AFFAIRS, IBAX HEALTHCARE SYSTEMS

Mr. SPEARS. Thank you, Mr. Chairman, Mrs. Johnson.

IBAX really appreciates the opportunity to be here to share the experiences that we have gained over the years in working with hospitals and physicians in implementing patient billing, patient accounting, patient management systems and office practice systems.

We have also been very active in the last few years in many industry groups, including WEDI, HL7, the ANSI Health Informatics Standards Planning Panel, which I would like to address in a separate statement just a little bit later.

One of the things that we found in our experiences is that, as we have heard from the various provider groups and the insurance groups, everybody is acknowledging that we have a nonstandard and nonuniform system. And, indeed, at every single center or site that we install a system, we have to customize to meet unique requirements.

We have built our systems around the National Uniform Billing Committee's guidelines on the UB–82 and soon-to-be UB–92, yet we implement that—customized at every single site.

We also experience what many providers experience, only we do it on a nationwide basis and they do it within their own setting, in that every provider is different, and we find that even Medicare is different as we move across the country from State to State and carrier or intermediary to each other to the next grouping.

And, in fact, what we find also is that there are some States that we ourselves have labeled nonuniform States, and there are about four of them across the country. In one of those States, New York, we did an internal study at IBAX that we determined our costs of doing business in the State of New York were twice that of a uniform State, and, to be honest with you, I don't recall that State, but it was in the Midwest.

Now, admittedly, that study was done before the pilot project on the single-payer system in the State of New York, but, nonetheless, the same impediments are still there in the State.

We read the possibilities of administrative simplification that were in the press release from the committee. We have experience with many of those today. They are nothing new and revolutionary. They are just things that need to happen uniformly across the country. And we believe that legislation is necessary to make that happen.

We do have a few recommendations, most of which are included in the written statement, but one thing that I want to make a point of is that we need to absolutely have clear goals about what it is we are trying to do. If we have clear goals, we can achieve much more with a clarity of purpose than we can with putting things on paper without much definition.

Standards for all data and data transactions are extremely important, and much of what we see in the literature and what we have seen in proposed legislation to date references a microcosm of

the standards world, and we really believe that we ought to be focusing on the American National Standards Institute and specifically the Health Informatics Standards Planning Panel which was formed over a year ago in order to coordinate the efforts of various standards setting organizations in health care so that they don't step on each other's toes as well as don't duplicate each other's efforts.

I would also like to see the government let the industry do its job. You know, HCFA has offered free software to providers, and some providers have taken HCFA up on that offer of free software, but I would submit that it adds little value for the provider that took the software because it does not integrate anything into that provider's current system. So, instead of getting something on paper today, I get something electronically and then I can print it at my site and then manually enter the data that I got electronically, so it really adds no value to the system whatsoever.

We think that the government needs to focus on outcomes and outcomes measures, and we need standard approaches to that. The AHCPR is currently doing a study to aggregate differing State data because none of the State data is compatible, and so that is the reason why they are undertaking the big study. We believe that needs to happen.

Lastly, we don't think that we are going to achieve the goals of administrative simplification without a legislative mandate. We have heard many people today talk about the voluntary effort that is taking place, and it is taking place, but it is a very slow process. It is not a rapid process.

The shoe does need to drop. We do need a gun to get us out of the starting gate to make all of this happen.

We will save money. Nobody knows how much money we will save, but we will save money depending on what we implement and coordinate that with health care reform.

But the real savings isn't going to come from administrative simplification. Administrative simplification is going to set up an infrastructure such that any health care reform proposal that we put in place can happen, and the only way we are really going to see significant savings is with a paradigm shift in the way we deliver health care such that the information will be available to the care givers in order to make appropriate decisions at the time that decision is made.

Again, we thank you for the opportunity to be here today.

Chairman STARK. Thank you very much, Mr. Spears.

[The prepared statement follows:]

TESTIMONY OF JEFFREY B. SPEARS
IBAX HEALTH CARE SYSTEMS

Good morning, Mr. Chairman and members of the Subcommittee. I am Jeff Spears, Manager of Government and Industry Affairs for IBAX Healthcare Systems of Longwood, Florida. IBAX Healthcare Systems, a partnership formed by IBM Corporation and Baxter Healthcare Corporation, is a leading Health Information Systems (HIS) company that develops and licenses software to more than 700 hospitals and over 7,000 physician offices nationwide. IBAX products form the "backbone" of the patient management, and billing systems at these hospitals and physicians offices, enabling them, among other things, to monitor costs, assemble patient databases, and submit claims electronically to public and private payers. IBAX very much appreciates the opportunity to appear before the Subcommittee and share with policy-makers the experience and insight we have gained from developing, installing, integrating, and supporting the systems referenced above.

As a company, IBAX is also involved in a number of industry initiatives and organizations. I am Chairman of the Health Industry Manufacturers Associations (HIMA) HIS Task Force on Insurance Issues. Additionally, IBAX is participating on the Workgroup on Electronic Data Interchange (WEDI) Technical advisory Group's Workshop on Uniform Data Content/Standards Implementation. Other industry activity that IBAX participates in includes the American National Standards Institute (ANSI) Health Informatics Standards Planning Panel, Health Level Seven (HL7), Computer-Based Patient Record Institute, American Society for Testing and Materials, and ANSI X12.

EXPERIENCE WITH THE CURRENT HEALTH CARE SYSTEM

The administrative aspects of our current health care system are far from uniform and standard. As an HIS company, we are very much involved in implementing patient accounting and patient management systems. We have yet to install a system that did not need to be customized due to the lack of standards and inconsistencies with which the various payers, both public and private, impose their requirements on the provider community.

Within the public payer system of Medicare, there appear to be no national standards. We see as many ways to "slice the pie" as there are carriers and intermediaries to process Medicare claims. Many believe that we have a single, national program for Medicare, but in reality, we have many regional, state, and local methodologies that implement requirements of the Medicare program in many different ways.

What makes matters worse, in terms of inconsistencies, are states that are what we call "non-uniform." Non-uniform means that the state uses bill forms other than the commonly accepted UB-82 and HCFA 1500 form for claims. There are four such states: New York, California, Michigan, and Pennsylvania. It costs IBAX twice as much to develop and maintain systems for use in a non-uniform state as it does in a uniform state. These additional costs are related to both the non-uniform claim forms as well as inconsistent data requirements.

POSSIBILITIES FOR ADMINISTRATIVE SIMPLIFICATION

As outlined in the Subcommittee's press release announcing this hearing, there are several examples of administrative simplification reform suggestions. IBAX would like to comment specifically on these proposals:

1.) **Use of standardized, electronic health insurance cards, with appropriate confidentiality and privacy protections.**

IBAX has experience with "smart cards," or electronic identification cards. Our experience does not relate to a card used for insurance identification but, rather, with use of the card as a patient identifier. This technology has significantly reduced the amount of time and the "hassle factor" associated with repeat admissions and registrations to the same facility for continued provision of care. By using this technology for insurance identification purposes, the provider will also be able to reduce the amount of time spent in the initial admission/registration process as well.

2.) **Requiring the use of uniform claim forms and coding systems that would be accepted by all insurers and public payers for electronic billing.**

IBAX's experience with claims has been outlined above. We have considerable experience with electronic claims as well. The multiple formats and differing edit criteria by payer have led to increased costs for supporting electronic billing methodologies. By making the formats and data content uniform, the costs for ongoing maintenance and support of the process would be reduced.

3.) **On-line verification of eligibility and benefits through direct access to payer computer systems.**

By implementing the ANSI X12 standard for eligibility and verification of insurance benefits, the provider community would have a significantly reduced need for telephoning insurance companies for this information. There would be an "instant" availability of this information. Insurance companies would also benefit by not having to staff this function.

4.) **Processing of all claims through regional consortia.**

With the lack of standards for billing formats and edit criteria, the processing of claims through regional consortia, or "clearing houses," is a good idea. This is done today in the banking industry via the automated clearing houses in terms of routing for funds transfers. However, the need for such consortia may not be as great with a true uniform claims standard.

5.) **Use of electronic medical records for both medical and administrative support which, subject to appropriate privacy protections, could be used in extracting data for responding to requests from utilization review entities.**

The electronic medical record is an extremely important concept that needs to be brought to fruition. Standards for this record would not only allow for its use in data reporting activities, but would also enhance the quality of care provided by having logical groupings of information, intelligence surrounding the information, and the immediate availability of the information to the clinicians providing patient care.

6.) **Electronic transfer of funds between payers and providers.**

Of the administrative simplification reform suggestions put forth, this one has the most potential for cost savings in the provider community. Standard claims would reduce systems costs, but electronic payment and funds transfers have the potential to allow providers to re-deploy staff in other productive areas of the health care delivery system, or reduce staff to achieve real cost savings.

7.) **Development of standardized audits and screens to be applied to bills by all insurers and public payers.**

This proposal, combined with standardized claim formats and data content, will be a major step in eliminating a significant source of increased cost in the claims processing environment. HIS companies, providers, and payers would benefit from the reduced costs associated with maintaining their systems.

IBAX RECOMMENDATIONS

IBAX enthusiastically supports reform efforts to simplify current administrative procedures. However, we urge policy makers to thoughtfully address the technical issues that will have a substantial impact on the practical functioning of whichever administrative reform measures will be enacted into law. Unfortunately, the bills introduced to date in the 103rd Congress do not adequately address these technical issues.

Our concerns and recommendations are set forth below.

Uniform Informatics Standards Should Be Established
Informatics standards enable computers to communicate efficiently with each other through electronic data interchange (EDI). Informatics standards specify the discrete items of information (data elements) that are needed for each type of communication, the ordering of those data elements, and, generally, the number of characters in each data element. Fortunately, informatics standards enable entities to communicate with one another, even if they all have customized computer software from several different vendors. A payer does not need to require that providers have a specific HIS software package to capture substantial savings.

In the health care industry, a great number of independent entities need to store and share information (e.g., hospitals, physicians' offices, payers, utilization review agents, and researchers). Many providers have invested in HIS software to store and retrieve data for a variety of purposes. One of the functions that HIS software accomplishes is communication with payers (both public and private) and utilization review agents. In recent years, computer links have cost-effectively replaced a substantial number of telephone calls and letters, saving significant administrative expenditures.

However, efficiencies and savings will not be achieved unless Medicare fiscal intermediaries and carriers, state Medicaid programs, HMO's, and other payers all conform to uniform national informatics standards. Unless radical changes are made in the financing and delivery of health care, the vast majority of providers will continue to treat patients covered by a variety of health benefit plans. Thus, providers are likely to need to communicate with a variety of payers and utilization review agents. HIS systems that must contend with numerous incompatible requirements from payers are more costly for providers to acquire. In addition, providers faced with incompatible requirements must spend more time and money to train staff to handle more complex systems.

If informatics standards were permitted to vary from state to state -- as might occur if legislation is enacted that encourages states to experiment with payment systems and reporting requirements -- providers, and ultimately payers, would incur higher costs to acquire software to meet these varied requirements. In addition, software at hospital systems that serve patients from more than one state would be significantly more complex and costly. Thus, states should NOT be able to request exemptions from using uniform national informatics standards.

The legislative proposals that have been introduced in the 103rd Congress reference the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12. Unfortunately, the ANSI ASC X12, by itself, does not adequately address the need for uniform informatics standards in many significant aspects of health information systems. HIS companies, providers, and payers realize the need for uniform informatics standards. These parties have established an effective process for standards development. ANSI has created the Healthcare Informatics Planning Panel (HISPP) to coordinate the development of health informatics standards. HISPP directs the efforts of ANSI ASC X12, Health Level Seven (HL7), American Society for Testing and Materials (ASTM), and others to develop informatics standards for many EDI and other functions. When similar information must be communicated for more than one purpose (e.g. the patient's name is needed for benefit eligibility verification, billing, and other purposes) HISPP ensures that the various standards do not require incompatible formats for that information. If additional standards are mandated as part of a legislative initiative, HISPP should coordinate their development to avoid duplication of effort and incompatibility with existing standards. Providers and payers will bear unnecessary costs if standards are developed without HISPP coordination.

Private Development of Software
Private HIS vendors, not the federal government or a government-chosen contractor, should develop software for providers. The private HIS industry is the most familiar with the functions required and would therefore produce the necessary software in a much faster time frame and at a lower cost to the health care system.

Some of the legislative proposals in the 103rd Congress have provisions for providers to receive nominally free, public domain software for such functions as benefits eligibility verification, claims, and remittance. The desired cost savings from such an effort will not be achieved without full integration of the software. Customization would need to occur to integrate the software with the providers' HIS. Such software would actually involve significant additional, unintended costs to the providers that would result from the integration effort.

HIS vendors provide significant services for providers in addition to fully integrated software. Such services include installation, 24-hour-per-day support that ensures providers can always meet the needs of patient care, software updates to meet the frequently changing requirements of providers, payers, and other parties. Since HIS companies are most familiar with the providers' overall systems, they should be responsible for providing cost effective solutions.

Freedom to Customize Presentation of Data (Screen Formats)
While minimal standards for data elements for all HIS software applications should be established, the standardization of the presentation of data (screen formats) is going a bit too far. Variation on the presentation of data inside hospitals and other providers allows customization to meet the unique needs of each provider, and will not interfere with the government's or other entities' collection of data (e.g. national expenditures or outcomes reporting).

Additionally, varied screen formats are not unduly burdensome for software users. Because each provider typically works with only one HIS vendor, that provider's admissions, patient accounting, administrative and clinical staff need only learn one set of screen formats. Physicians who have privileges at more than one hospital already are accustomed to working with a variety of paper formats. As HIS companies discover which formats are the most helpful, market forces will spur competing HIS companies to improve the manner in which their HIS products present data.

In short, standardization of screen formats will only slow down the development and evolution of the process. IBAX believes this forces unnecessary standardization on the industry.

Automated Patient Records and Patient Outcomes
Today there are inconsistent definitions and great variety in terms of available Clinical Information Systems. This is due, in part, to differences in practice patterns in the delivery of health care throughout the country. There is not a widely accepted standard defining the automated patient record.

IBAX believes that with the proper mandate, the health care industry would gain consensus and develop a standard that defines the automated patient record. Additionally, the industry would also move toward developing effective outcomes measures, such as those recently espoused by the National Committee for Quality Assurance in the managed care sector.

Implementation Time Frames
IBAX endorses the objectives of the time frames as outlined in H.R.200. While aggressive, we do believe they are achievable. However, to achieve them, the following must occur:

* The goals MUST be specific and crystal clear;
* Legislation mandating the use of standards must be enacted early;
* Specific standards should be adopted, for example:

Enrollment	ANSI X12.834
Eligibility	ANSI X12.270/271
Claim Submission	ANSI X12.837
Claim Payment/EFT	ANSI X12.835

  (others are in development);
* Minimize exemptions to these requirements.

Additional action that would facilitate implementation involves removal of certain barriers. Hospitals and other health care facilities could benefit from a lengthening of the generally accepted depreciation schedule of five years for computer equipment and software. We recommend a doubling of the allowable period from five to ten years. For an automated patient record, this certainly seems appropriate.

The health industry is a lagging industry when it comes to investment in information technology. Exemptions from sanctions for violating potential antitrust or safe harbor provisions would also be appropriate. For example, a more common organizational arrangement seen in health care is the physician-hospital organization or the formation of community networks among institutional providers. As health care reform evolves and begins to involve health alliances, these organizational models will become more commonplace. Greater investment in information technology is more likely if existing sanctions were removed to allow the necessary networking to take place.

Informatics Standards for Uniform Reporting
As health care expenditures and outcomes reporting become required to be submitted electronically as part of health reform legislation, national uniform informatics standards must be required. To avoid unnecessary costs for the modifications to HIS software, states should not be allowed to vary data requirements, in any way, shape, or form, from the national uniform standards for data or format, as some current proposals permit.

Sanctions Should Be Effective and Permanent
Once uniform informatics standards are established, all payers and providers should be required to conform permanently. Sanctions should be sufficient to assure that all parties will conform to the standards.

CONCLUSION
IBAX believes that administrative simplification as discussed today will provide the necessary infrastructure to support any reform initiative. There will be cost savings to be achieved through implementation of administrative simplification. The Health Care Financial Management Association (HFMA) found in their study a savings of approximately $5 billion; the Workgroup on Electronic Data Interchange (WEDI) has estimated a savings of $4 to $10 billion (which only included estimates of savings for the insurance industry); Arthur D. Little estimated a savings of more than $36 billion in their telecommunications study.

An even greater cost savings will occur through modification of physician behavior. It has been widely shared that physicians control 70 to 80 percent of the nation's $900 billion in health expenditures. If we can impact physician behavior through the use of information technology, then real cost savings can be achieved through the elimination of less appropriate, unnecessary, or duplicative ordering of tests, procedures, drugs, and supplies.

Chairman STARK. Mr. Frost.

STATEMENT OF FRANK E. FROST, PRESIDENT, FF255, INC., OMAHA, NEBR., ON BEHALF OF HEALTHCARE USA,

Mr. FROST. Thank you for inviting me here. I am Frank Frost from HealthCare USA.

I am presenting a system of true health care transformation in the United States. The system involves our patent pending computer technology and a nationwide integrated health care network. Together, these two concepts can potentially save up to $200 billion per year. The savings are based on health care costs of $900 billion for the current year.

The system will reduce administrative fees from 25 percent to 3 percent. It will shrink claims processing from $1.45 to 25 cents per claim, and, when implemented, this system can be totally financed by user fees.

The key parts of our system are the system is totally paperless. It uses a machine-readable card that supports immediate authorization for services. Centralized patient records are immediately available nationwide so that true portability is ensured.

The system provides a database to enable nationwide quality assessment and research data. It controls fraud, access and abuse by using centralized records with consumer and provider security profiles. Our program delivers instant payment to providers by electronic funds transfer, therefore eliminating billing.

The system enables government to instantaneously monitor health care expenses so we know at any minute exactly what has been spent for health care. This allows for fine tuning the cash flow, keeping health care dollars in circulation. This is what I call just-in-time funds availability.

Our system provides for State and local jurisdiction administration of the program. We ensure privacy of information by utilizing our unique numbering system and a security access code that cannot be decrypted. This protects individuals from government penetration.

Our retrieval technology will allow providers to make better decisions. It will provide quality review with predictable outcomes. This helps providers market their services. It also gives patients the information they need to choose a provider.

This system will operate on any computer from mainframe to personal computers. We can begin implementation in 1 year and be fully implemented within 3 years from the start date.

As I said earlier, it can be totally financed by user fees.

Thank you, Mr. Chairman.

Chairman STARK. Thank you, Mr. Frost.

[The prepared statement and attachment follow:]

**TESTIMONY OF FRANK E. FROST OF HEALTHCARE USA
PRESENTED TO THE SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON WAYS & MEANS
MAY 25, 1993**

Good morning Mr. Chairman and members of the Health Subcommittee. I am delighted to be here to present a PATENTED HEALTH CARE TRANSFORMATION CONCEPT that will provide improved health care for all citizens of the United States with no increase in taxes.

My name is Frank Frost. I represent an organization called HealthCare USA. I am a mathematician who has been involved in computer systems and software design for over 25 years. I have an extensive background in the health care industry, and was involved in the first Title XIX program for the State of Colorado.

Last year I received a patent pending status on a software system that will establish an Integrated Health Care Communications Network (IHCN) throughout the United States. The three key components of this system are:

* Immediate on-line authorization for health care services and products

* Centralized availability of health care records at the time of service

* Immediate payment to the provider for service/products by electronic bank transfer to provider's account

Based on current health care costs of $800 billion annually, the Integrated Health Care Network would yield a total annual savings of $176 billion by shrinking administrative fees from 25% to 3% and reducing claims processing costs from $1.45 to $.25 per claim. Our projected 3% administrative fee charge includes claims processing. The efficiency of our patent-pending system in combination with the Integrated Health Care Network makes these savings realistic.

I would like to explain how our system works.

CONSUMER

Each citizen of the United States will be issued a health care card embossed with a unique identification number. This number identifies the card holder as the exclusive owner of his/her medical records and guarantees access to an expanded and basic core of health services. The patent-pending unique numbering system and access code assures privacy of information.

The consumer presents his/her health card to the provider who swipes the card through a point of service device similar to those used by merchants for credit card services.

The consumer receives immediate care because of on-line authorization by computer. No paperwork is involved.

PROVIDER

The provider inserts the subscriber's card in a point of service device to read the subscriber's ID. The point of service device identifies the provider. The provider has a security profile that controls his/her access to the health care records. For example, a dentist would not have access to the same information that a gynecologist would have.

The provider accesses patient records on a computer screen which includes complete medical history, test results, and any genealogical information which will aid the provider in diagnosis and treatment decisions.

Upon completion of service, provider files immediate up-to-date treatment record with central database, eliminating claim forms, and receives immediate payment at time of delivery of service via electronic bank transfer of funds to provider's account. Paper factory is eliminated.

Providers who do not have computers will access the system by telephone, and receive voice authorizations. Provider will receive payment for services upon receipt of medical results at the local data entry center.

CONSUMER ELIGIBILITY

Every citizen of the United States is eligible to participate in the health care program, and may choose any provider that fits their needs.

If an individual elects not to participate that person can be given a tax credit to purchase the health care of their choice.

PROVIDERS/CARE ELIGIBILITY

Provider/care sanctioned under the basic health benefits package would include physicians, dentists, eye care, hospitals, clinics, pharmacies, physical therapists, nursing facilities, chiropractors, home and respite care, mental health services, certified holistic providers, alternative health care, expanded preventative care, long term care, and substance abuse treatments.

SECURITY/PRIVACY

The health care data stored in the database is owned by the person they are about, except in cases of custodial care.

An encripted access code maintained by the owner of the health care records is stored in a way that it cannot be decrypted. This protects the individual data from government penetration.

All the data elements stored in the health care records are mapped into a security profile. Every provider has a security profile that controls their access to the people-owned data. A dentist would not have access to the same data that a gynecologist would have.

FRAUD CONTROL

Providers and/or the system can control fraud by refusing fraudulent requests for services and products. For example, a drug addict visiting several providers within a few days to get narcotic prescriptions would be quickly identified and denied.

UNIQUE FEATURES AND BENEFITS OF THE SYSTEM

UNIQUE NUMBERING SYSTEM

The individual is at the heart of and in control of an Integrated Health Care Network (IHCN). Every eligible subscriber will be assigned a unique number that is embossed on a machine readable, plastic, health care authorization card. This card asserts that the card holder is the exclusive owner of his/her medical records.

This number is the product of the patent-pending "Unique Number Assignment and Genealogical Retrieval" invention.

Industries throughout the world have been plagued with the challenge of creating a truly unique numbering system that cannot be duplicated. Solutions to date have been clumsy to manage and have not been truly unique. We have a solution. Our patent-pending unique numbering system guarantees an unlimited supply of unique numbers with absolutely no duplication even though they may be assigned simultaneously throughout the United States. This assures that there will not be any mix-up of patient records and solves the problem of how to identify correctly people with identical names.

GENEALOGICAL RETRIEVAL

The patient records are organized genealogically to allow access to valuable heredity factors that can assist the provider in making better decisions about health care.

Genealogical information can provide a valuable source of data for research.

Using our technology of combining the unique numbering system with the genealogical retrieval, the records of the entire population can be sorted and retrieved in a timely fashion. This is an essential element to a national patient database system and crucial to achieve the $176 billion savings projected.

BENEFITS TO THE PEOPLE, PROVIDERS AND OUR COUNTRY

The people will enjoy an improved quality of health and we will reduce health care costs because:

* People will seek treatment earlier when experiencing a health challenge impacting health care costs. Example, a virus identified early can prevent days in recovery and require less medication.

* Universal access of medical records will reduce needless excesses and duplication of services/products. General Practice physicians will have diagnostic complication data available that will reduce the need for costly specialist referrals.

* Releasing people from hospital early to convalesce at home presents an employment opportunity for traveling nurses and a cost savings to the country.

* People with no health benefits who become ill delay going to the physician until they have to be treated at the emergency room of the hospital. This is an expense that will be reduced substantially when people can seek treatment early.

* The system will provide health care data that can predict outcomes for a specific illness and related treatment. For example, an individual needing open heart surgery can access the history of procedures and medication used by specific surgeons and compare the recovery time and use this information to select the surgeon for themselves.

BUDGET MANAGEMENT

The system's "just-in-time" cash management concept provides a statistical cost analysis daily which gives an account of payouts month-to-date, year-to-date, yesterday or today up until 3:00 p.m., for example. This provides the opportunity to employ just-in-time funds availability to synchronize cash flow requirements, eliminating the need for an inactive large pool of funds to cover unknown health care charges. This improves the economy by keeping health care dollars in circulation.

SAVINGS RETURNED TO THE PEOPLE

Our program provides health care to every citizen of the United States. It will cost about $100 billion to provide health care to the 37,000,000 population without health care benefits.

This leaves $76 billion per year that may be redirected towards deficit reduction.

IMPLEMENTATION

PROGRAMMING

The system is supported by four basic tables. They are:

* The Subscriber Table
* Products and Services Table
* Provider Table
* Payment Table

These tables and their associated indices identify data and control access to the health care system. The system will use standard medical nomenclature and codes for products and services. The detailed interaction of these tables are spelled out in the patent application.

The programming would be developed to be in the public domain. The system will run on all platforms from mainframes to micros to personal computers. Identical programs would be implemented throughout the Integrated Health Care Network.

REGIONAL DATA CENTERS

To ensure efficiency within the Integrated Health Care Network, we will establish four regionally-based, multi-state administrative centers throughout the United States. In turn, each regional administrative center establishes and governs the competitive environment within which other private entities may participate.

Although the records are centrally available to support health care delivery, state and local jurisdictions are cleanly delineated.

To realize maximum cost savings, data taken from the local data processing centers can be batched and transmitted at night to the regional and central data processing centers when line costs are reduced.

See diagram "A"

COMMUNICATIONS NETWORK

The largest task of all is establishing the communications network and facilities. We have the people at HealthCare USA with the expertise to expedite this phase of the implementation.

IMPLEMENTATION TIMING AND PROJECTED COST

HealthCare USA can begin a staged implementation of the Integrated Health Care Network within one year from the starting date, with full implementation within three years.

ESTIMATED DEVELOPMENT COSTS

The estimated development costs are:

* Data Centers $1 billion
* Hardware - $1 billion
* Software - $250 million
* Communication Network - $500 million
* Authorization Cards - $250 million

Total Costs = $3 billion

ADMINISTRATION

The system will be administered by a not-for-profit foundation in conjunction with a governing board made up of federal, state, community governments, businesses, consumers, and providers.

The board will direct policy, oversee management and define and regulate costs of services and products.

The system utilizes patent-pending breakthrough technology to easily accommodate ever-expanding peak loads of transactions.

OTHER USES OF THE PATENT-PENDING CONCEPT FOR COST REDUCTION

The concepts of our patent can be applied beneficially to any governmental agency or department where there is a need for organization,identification and retrieval of records, for organizing and retrieval of information; for accurate inventory management; for project planning

A "PEOPLE FIRST" SOLUTION TO HEALTH CARE REFORM:

- The <u>individual</u> is at the heart of and in control of an **INTEGRATED HEALTH CARE NETWORK (IHCN)**. Every individual in the **IHCN** receives a health care <u>authorization card</u> which asserts that the card holder is the exclusive owner of his/her medical records.

- To ensure <u>efficiency</u> within the **INTEGRATED HEALTH CARE NETWORK**, the **NATIONAL HEALTHCARE FOUNDATION** will operate <u>five</u> regionally-based, multi-state **Administrative Centers** throughout the United States.

- In turn, <u>each</u> regional **Administrative Center** of the **FOUNDATION** establishes and governs the competitive environment within which other private entities may participate in the sub-regional administration and operation of the **National EDP System**.

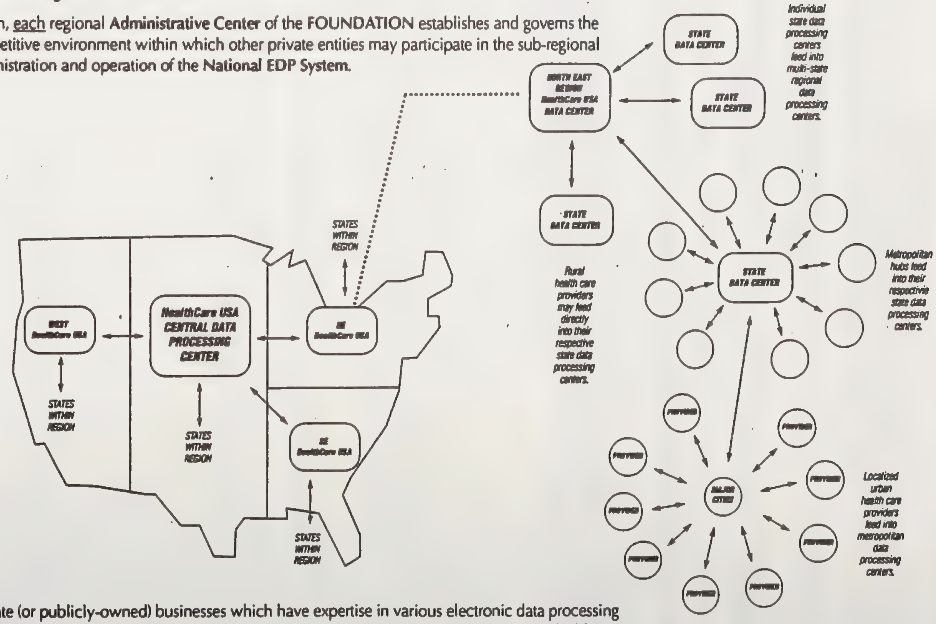

Diagram A

- Private (or publicly-owned) businesses which have expertise in various electronic data processing methods (insurance companies, hospitals, information processing companies, etc.) may <u>bid for the right to operate</u> the **National EDP System** within certain sub-regional areas.

Chairman STARK. Dr. Korpman, I find your testimony interesting, and I agree with it, but—I don't mean to sound indifferent or arbitrary, something I am accused of all the time—but the jurisdictional requirements that we deal with around here really restrict this committee—and if they didn't I would—to the financial aspects of bill paying and insuring beneficiaries that we now cover, the Medicare beneficiaries.

We have tried pretty religiously, as we say in the vernacular, to stay out of the doctors' office, not that that is not important and in some area of governmental concern. The AMA would dispute that, but the States have licensing boards and review organizations. Chairman Waxman and the Energy and Commerce Subcommittee on Health do enter into the issue, for instance, of FDA and physician standards and licensing.

I would just suggest to you that I don't think that we do a disservice if we just for now cue to that. I would suggest that we have a big enough job trying to get the bill paying and the standardization accomplished. It may be just a small part of the medical care delivery system, but it also occurs to me that, certainly in the situations I have observed, that they are pretty separate.

This chart that Mr. Bernd gave me with 108 procedures, doesn't really get into the medical records storage. This is just dealing with collecting the bills and collecting the payments from the insurance company. I share with you your concern for medical records, and I think you are right on. I think they are kept in the manner of the dark ages. They must have been designed by the AMA for all the modern technology they use. But is there any reason that we would cause any harm by going ahead and concentrating on the reimbursement side of the coin and hope that the professional practice side will catch up with us?

Dr. KORPMAN. If the two were truly separate you could take that stance and get away with it.

As you heard several people—Mr. Bernd pointed out that many times to pay the bill they must submit the entire chart. As Dr. Clowe pointed out, one of their big issues was, again administratively, to get paid they had to have utilization review and quality assurance, and all of these processes involve, almost exclusively, clinical data.

It has been our observation, working both sides of the street, that every time you fill out a UB–82 each payer for each diagnosis has some random required combination of clinical data in which they expect you to submit everything from 15 elements to the whole chart.

Chairman STARK. But let's assume just for a moment that it will be Medicare for all, just so we can talk about something with which I am only vaguely familiar, but I am not at all familiar with these other issues. And I understand that Medicare has some requirements. You know you can only do two cataract operations—if you do the third cataract operation on an individual, generally, it will flash a warning light. Some bureaucrat 5 years later will figure out that maybe that is one we shouldn't have paid for.

But let's take that, for example. Isn't there a lot to accomplish just to get the bills paid expeditiously and just in shortening the process. There is not much medical stuff here. This flow chart

mostly deals with collecting bad debts and making sure the bill gets sent to the right insurer. If we can simplify that procedure, maybe we can send a few technicians and computer experts into the medical records department and help them get up to speed.

Dr. KORPMAN. And we should simplify that procedure. We certainly agree—HIMA speaks strongly in favor of that.

Many of the complexities, let me reiterate, of doing that procedure have to do with providing screens and utilization review data and quality background data, all of which is clinical and which really would like——

Chairman STARK. Where do you practice? Do you practice medicine?

Dr. KORPMAN. Yes.

Chairman STARK. Where? What State?

Dr. KORPMAN. California.

Chairman STARK. OK, in California, who has more complex requirements when you bill? MediCal, or whatever your intermediary is for Medicare, or Blue Cross? Or Aetna under a managed care plan if you have them? Or one of the big ones? Which is more complex? Do any one of the four stand out?

Dr. KORPMAN. They are all complex in a different way.

Chairman STARK. If you just had one of them you would simplify your life?

Dr. KORPMAN. Yes, that is true with little question.

Chairman STARK. That is sort of what I am getting at. When it comes to keeping records on patients and outcomes research and stuff, I think that makes ultimate good sense to me. That is something that somehow has to start, it seems to me, with the medical schools, teaching. I am not going to even hint at the idea that we ought to tell doctors how to keep records.

Dr. KORPMAN. I wouldn't, either. That is different from saying we are going to collect clinical data in support of paying bills because you can't take out the third cataract and you can't do pregnancy tests on males or whatever seems apropos. And HCFA, in developing the uniform clinical data, said some of these things, started to pick out some of those things.

The trouble is, everybody has their own set of clinical screens, and they all require clinical data, and most of our time is not spent finding the billing code, but in gathering the supporting clinical data.

Chairman STARK. Don't you think that statistical surveys will begin to sort out the outliers?

Dr. KORPMAN. Statistical surveys have the same data acquisition problems——

Chairman STARK. If you are using the standard system and the standard set of codes, won't you pretty quickly be able to identify if somebody is doing three times as many C sections on the average per number of patients in a community? Won't that stand out under some kind of a sort and then trigger some further investigation?

Dr. KORPMAN. Sure. And some of those things we do now.

I am just pointing out that, for administrative capture, much of the time we spend and many of the rejections are for inadequate, inappropriate clinical data, and it seems to remain the vast orphan

child of the administrative simplification discussion. Let's get the procedure codes a little more uniform. That is a good, important thing.

It is just that payment, in fact health care in general, is not about procedures. It is about patients. And even from the perspective of payment for procedures, it is still about patients: Was this the right procedure and the right payment for this patient?

Much of the legislation the last few years has been trying to get better at ascertaining was this the right procedure to pay for for this patient or the right test or the right exam, and that requires something better than "let's use a standard billing format," although a standard billing format is obviously an important part of that.

I thought you dealt with it respectably in H.R. 200. That was properly laid out.

Chairman STARK. It doesn't go as far as you would like to, obviously, but it goes to the limit of my jurisdiction.

Dr. KORPMAN. I thought within the limit of the jurisdiction of this committee it was the appropriate place to say this is the clinical data which also must come in so that in a standard form we can begin to make financial adjudications as opposed to the random and poor way it is done right now.

So you can't do it all, but I thought what you did in H.R. 200 was exactly the right thing.

Chairman STARK. Thank you.

Mr. Houtz, you brought up the issue of our stultifying competition. And if the Government mandates some kind of a system we might not have innovation. I am sensitive to that, but it seems to me that all we are talking about is a system that is as restrictive as whatever system or protocol is now accepted by the major credit cards. They all use the same protocol, and most of them allow for transferability of vouchers.

And I go back to the Federal Reserve which sets a standard by which banks will accept one another's checks and in what fashion. Unfortunately, the House Sergeant at Arms didn't adhere to that or we wouldn't be in this soup we are in, but that still allows more competition than you ever want to see.

How many pieces of junk mail do you want to get from credit card issuers or from banks offering you a variety of gimmicks on checking accounts? And I just hope we don't get that mixed up because I do get some sense that there are people who have it in their psychology to resist any government rules, speed limits or tax requirements or anything else. The banking industry had a couple hundred years to develop this transfer system, way before computers, so they kind of eased into it. We, unfortunately, particularly in the government side, are way behind the power curve on information data transfer.

Do you think that if we just established the protocol—and, as somebody suggested, I would just as soon make the basic software. I can't believe that that software issue is very complex. The competition, it seems to me, goes on in the hospital side in management and how they use the data, what they do with the money after they get it, which leaves a lot of room for all of you who want

to sell management programs, bookkeeping services or sophisticated accounting services.

This seems to me to just be a tool that would speed up the processing of claims, depending on what comes out of health reform, whether those are simpler claims, fewer claims or more. God help us if we get HIPCs. This might even make those understandable, although I think that is beyond the realm of rocket science at this point.

Can you live with just that kind of a simple structure? Does that leave you enough room for your competitive juices to flow?

Mr. HOUTZ. We are very much in favor of the standards being established and promoted by the Federal Government. We think it is important that the standards be implemented, and the industry, we feel, is going to do what it is going to do towards bringing electronic claims to 100 percent during the next 4 to 5 years. I believe that if you people legislate it, it could happen in 2½, 3 years, so, I mean, that would be well worth the effort.

Chairman STARK. Well, look at the Federal Reserve. You don't have to join it, you know, as a bank, but for a lot of banks it would be very difficult not to. And that is what I would anticipate we would do federally is to say this is how we are going to pay the claims. If you don't want to, fine with me, but if we are paying a third to 40 percent of them and people don't fight it, that might just be enough of a standardization to get everybody else to say, yeah, that is how we will follow along. Maybe not.

It might take more than that, and it is a matter of, as somebody had suggested—Mr. Spears, I think—that we don't let 50 States write 50 different protocols or we would really be in the soup. And with all due respect to the wonderful work you are doing in New York State, unless it was the New York State system for everybody. I suspect you would agree with that, wouldn't you, Ms. Ryan?

Ms. RYAN. Absolutely. And we are working with companies that are establishing systems that link nationwide because we have many patients who are residents of New York that go outside the State and, in turn, have many people from outside the State that come in.

Chairman STARK. They all go to Florida, don't they? They are coming home now, though.

I want to thank all of you. As I say, this is something that I would love to see completed in this Congress.

I have to ask Mr. Frost, have you ever met Ira Magaziner?

Mr. FROST. No, I have not.

Chairman STARK. I read your testimony. You guys should get together. I think you would find that you have a lot of ideas in common.

Mr. FROST. I would love to have the opportunity.

Chairman STARK. With that, I thank the witnesses very much for their participation, and the committee is adjourned.

[Whereupon, at 1 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

HOME HEALTH SERVICES & STAFFING ASSOCIATION

HHS &SA
Established in 1978

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June 1, 1993

Janet Mays, Esq.
Chief Counsel and Staff Director
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Re: Statement for Printed Record of Health Subcommittee Hearing Held May 25, 1993

Dear Ms. Mays:

I represent the Home Health Services and Staffing Association (HHSSA). HHSSA is an association representing most of the nation's leading proprietary home health providers. I am submitting the following statement for the printed record of the Health Subcommittee hearing on issues relating to administrative simplification, held May 25, 1993.

Excess, often unnecessary, regulation in the health care field has resulted in excessive costs for health care providers. Providers must pass these costs onto their patients, thus adding to the soaring costs of health care. To prevent this, HHSSA feels the government needs to be more cost effective in its regulation of health care. Consideration of cost effective options and mechanisms for coordinating regulation of providers is a necessary component of any health reform legislation.

If Congress fails to coordinate federal regulation, it must acknowledge its share of responsibility for the increasing costs of health care. This conclusion is supported in a recent decision by the United States Court of Appeals for the Seventh Circuit. In a concurring and dissenting opinion, one judge stated that "If Congress concludes there is a need for two federal agencies - in addition to state agencies and professional organizations - to exercise oversight in the health care field, then Congress must acknowledge their responsibility for increasing the cost of health care." See Home Health Services and Staffing Association v. Martin, C.A. 92-1482 (7th Cir. January 28, 1993) (Opinion at p. 49).

In sum, Congress should ensure that health care regulation is better coordinated. In addition, HHSSA recommends that until the current health care reform legislative debate is completed, a moratorium be imposed on any new federal health regulations which inflict additional net costs on providers.

Please do not hesitate to contact me if you have questions or need further information.

Sincerely,

James C. Pyles

James C. Pyles

JCP/DLF/jhl

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University of Pittsburgh
UNIVERSITY OF PITTSBURGH MEDICAL CENTER
Vice President and Counsel

TESTIMONY BY GEORGE A. HUBER
VICE PRESIDENT AND COUNSEL
THE UNIVERSITY OF PITTSBURGH MEDICAL CENTER
BEFORE THE
HOUSE WAYS AND MEANS COMMITTEE
JUNE 1, 1993

Mr. Chairman, I am pleased to present testimony on behalf of the University of Pittsburgh Medical Center in support of simplifying the administrative process in the health care industry before the House Ways and Means Committee. The health care industry must address the issue of administrative inefficiencies and this hearing serves as a positive step in that process.

The University of Pittsburgh Medical Center supports administrative simplifications for several reasons including the benefits a more stream-lined approach would have on the accounts receivable department which is currently difficult to manage given the length of time between billing for services and receiving payment. For example, at the medical center, all billings are handled electronically which has significantly improved this process internally and has reduced overhead costs thereby reducing overall costs.

In addition, simplifying the administrative process would have a positive impact on the number of Full-Time Equivalents (FTEs) currently needed to properly comply with the various regulations and requirements governing the multitude of payers associated with an academic medical center. It is very time consuming and costly to operate a billing department when staff must be trained to respond to so many different guidelines and requirements.

The University of Pittsburgh Medical Center supports the concept of a uniform bill for hospital services similar to the "UB-28" form that was developed in the past decade. However, in order to obtain maximum compliance in the use of such a form, it is important that representatives from various health care providers, including academic medical centers, participate in the development of a standard bill.

In addition, the medical center is supportive of the use of standardized, electronic health insurance cards, with appropriate confidentiality and privacy protections provided the development of such a system includes the input of all players in the health care industry including providers of health care services.

The health care industry must address the issue of rising costs through inefficient administrative processes. As mentioned, the University of Pittsburgh Medical Center fully supports efforts in this direction and has implemented some innovative and cost saving techniques. The medical center would be pleased to work with the Committee in the development of administrative simplifications in any appropriate manner.

Thank you for providing the medical center with this opportunity to submit testimony on this important issue.

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STATE REGULATION OF PRIVATE HEALTH INSURANCE

THURSDAY, MAY 27, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:12 a.m., in room 1310–A, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
FRIDAY, MAY 21, 1993

PRESS RELEASE #13
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON HEALTH CARE REFORM: STATE REGULATION OF PRIVATE HEALTH INSURANCE

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on issues relating to State regulation of private health insurance on Thursday, May 27, 1993, beginning at 10:00 a.m., in room 1310-A Longworth House Office Building.

In announcing the hearing, Chairman Stark said: "Because the regulation of private health insurance is likely to be a critical component of any health reform plan, I asked the General Accounting Office (GAO) to examine the performance of the States in the regulation of private health insurance. This hearing will focus on GAO's findings and examine the capacity of the States to take on additional regulatory responsibilities."

Oral testimony will be heard from **invited witnesses only**. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND:

The United States is unique among major industrial nations in not supervising its insurance industry at the national level. Historically, the regulation of health insurance, like that of the insurance industry in general, has been a State responsibility. The McCarran-Ferguson Act of 1945 affirmed the traditional power of the States to be the primary regulators of insurance.

Most States require that policy forms sold to individuals and group health insurance issued in the States' jurisdiction be filed with the appropriate regulatory authority. State insurance laws also require insurance companies to meet a variety of requirements in order to obtain a license to do business. The exact requirements vary from State to State, but ordinarily specify the minimum amount of financial resources needed to establish the solvency of an insurer.

Most States do not regulate the premiums established by commercial health insurers, although they generally require or have the authority to require the filing of rates and rate information as part of their policy form filing and approval procedures. By contrast, most States subject the Blue Cross and Blue Shield plans to some sort of rate approval process.

A number of health care reform proposals would assign an extensive role to private health insurers. The Medicare-for-all approach, for example, anticipates that private insurers would administer payments and supply supplemental coverage for deductibles, copayments, and uncovered benefits. Employment-based proposals assume that private insurers would continue to cover a substantial majority of employees and their dependents.

(MORE)

The capacity of States to monitor and supervise health insurers is, therefore, likely to be a significant issue during future considerations of health care reform.

In response to a request from Chairman Stark, the General Accounting Office will present new findings from a study that examined the organization, operation, and performance of the States in the regulation of private health insurance.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Thursday, June 10, 1993, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

* * * * *

Chairman STARK. Good morning. The subcommittee will continue its series of hearings on health care reform intended to continue to build a foundation to work with the administration to enact comprehensive health care reform.

Virtually all the proposals, with the exception of the single-payer plan, envision a major role for private health insurance. Under the Medicare-for-all approach, which I have favored for some time, private health insurers would administer payments to providers and would also sell supplemental or medigap-type policies to supplement coverage for copayments and otherwise uncovered benefits. Under an employment-based plan, the private health insurers would continue to cover a substantial portion of employees and their dependents, as they do now.

Because the regulation of private health insurance is likely to be an important component of any health reform plan, and because the regulation of health insurance is currently a State responsibility, with the exception of the recent medigap changes, I have asked the General Accounting Office to conduct a comprehensive study to evaluate the performance of the States in regulating health insurance. The GAO will present a summary of those findings here today.

Many health care reform proposals would allow a major role for the States in health care reform, with varying degrees of Federal oversight. In my view, such oversight is critical to the successful implementation of a national health care reform plan.

The summary of findings by the GAO and testimony presented by our other witnesses should further our understanding of the current activities and the capacity of State health insurance regulators as we grapple to decide the proper role for States in the health care reform process.

Before proceeding, I want to note that the subcommitteee invited the National Association of Insurance Commissioners to testify on this important issue, but they declined to appear today. That is the bad news. The good news, of course, is that they have been replaced by their former president, who now pursues an honest living as a Member of Congress. [Laughter.] So we will look forward to the testimony from him.

I would like to now recognize the distinguished, bright, accommodating, congenial ranking member of this subcommittee, Mr. Thomas, for an opening statement.

Mr. THOMAS. Thank you, Mr. Chairman.

I do not normally react to the chairman's statement directly but, rather, offer my own. But based upon the content of the chairman's opening statement, I would like to make a few remarks about what we have in front of us, because I continue to be somewhat surprised by the General Accounting Office's studies that we have been looking at, apparently as a knowledge basis for moving forward.

I looked with interest at the press release that the chairman issued on this hearing, indicating that he had "asked the General Accounting Office to examine the performance of the States in the regulation of private health insurance." My understanding of a study of this type normally is that you would posit some degree of criteria for performance so that you could determine whether or not

the States measured up to that performance. Perhaps you could critique various concepts of performance, which we could then debate in the subcommittee, to go out and test among the States as to what we think is a good performance criteria.

I don't believe any of that was done by the GAO, and what I got out of it was a compilation of some numbers which, frankly—and we will find out—mean very little to me. I hope they mean more to somebody else, because if this is all we have, then I don't think we have laid any basis for examining just exactly what States are doing.

The press release goes on to say, "This hearing will focus on GAO's findings and examine the capacity of the States to take on additional regulatory responsibilities." If I have ever seen a setup coming—I am very interested in finding what GAO discovered in terms of the capacity of the States. It would mean that they would have to examine the resources of the States, the decisions of the State legislators and the Government bureaucracy made not to go into particular areas, the reason why they chose not to go into those areas, the areas they did go into, why they chose to go into those areas. Because to determine the capacity is to really understand why the States are doing what they are doing rather than a simple number compilation of what they do.

For example, one of the things I found interesting in the GAO study—and we will get into it in a minute, Mr. Chairman—were the number of people assigned on a full-time equivalency in an area without any kind of a foundation in terms of the differences between States, the makeup of industries, the activity, the size of the State, the problems that they have had through recessionary periods, the economic base of the State, what has occurred nationally and internationally in terms of that economic base, but simply a compilation of numbers, which, when it is through, it is interesting, but it certainly doesn't lay any kind of a basis for determining performance or the capacity of the States.

Finally, Mr. Chairman, when you say that the National Association of Insurance Commissioners declined to appear, I do think it would be fair to indicate that this was not the hearing that was planned at this time; and that when you ask a national group to appear, there are a lot of hurdles they have to go through to get clearance to speak. And I think a more appropriate phrase might have been that they "were unable to attend, given the short notice of the calling of the hearing," rather than to indicate that they declined, because I believe that presents a decision that they willfully chose not to appear before this subcommittee. And I can't believe anyone that was either formally represented by the distinguished gentleman in front of us or anyone who continues to meet the very difficult needs of the States through organizations such as this would willfully decline if they had any opportunity in a timely fashion to appear before us.

Finally, let me say, Mr. Chairman, that States are doing what States are doing in large part because of what the Federal Government has done through the mid-1970s. And just as we carved out a significant area for States not to be involved, I look forward with the chairman in working on a structure to include the States through Federal legislation in a far more meaningful role, and that

the future of the Federal-State relationship is healthy only if the Federal Government lets it be healthy.

I thank the chairman and look forward to the testimony of the witnesses.

Chairman STARK. Are there other comments or statements?

[No response.]

Chairman STARK. If not, it is my pleasure to welcome back in a somewhat different role than we have seen him before Congressman Earl Pomeroy of North Dakota. Prior to his election to the House, he was the insurance commissioner for North Dakota and, much to the relief of one of our former colleagues, chose to run for Congress rather than the Senate. He is a past president of the National Association of Insurance Commissioners. He has testified before us often, many times being critical of the way in which insurance commissioners perform their State-mandated roles, many times suggesting ways in which the Federal Government could supplement, complement, or, indeed, supplant those roles.

It will be interesting to note, Earl, how you feel about all these things now that you are on the other side of the table, but we are happy to have you back before the committee in your new role. If you have prepared a written statement, we will be happy to include it in the record. Why don't you proceed to discuss the topic of the day in any manner you are comfortable.

STATEMENT OF HON. EARL POMEROY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NORTH DAKOTA

Mr. POMEROY. Thank you very much, Mr. Chairman. I am delighted to be here today. I do not have a written statement, this hearing coming as it does in the middle of rather hectic hours on the Hill. I will be happy to either submit one following the hearing or just let the transcript stand for my printed statement.

The feeling I have testifying here is that the more things change, the more they stay the same. Another congressional hearing, I am again talking about State insurance regulation and responding, in part, to another GAO report, which I just saw yesterday afternoon. And again the topic is health insurance.

I have, I think, in each of the last 7 or 8 years been before this subcommittee discussing this matter and in similar contexts.

There is a very important distinction, however, marking this morning's meetings, and I am not talking about my new employment. I am talking about the fact that this hearing comes on the eve of a proposed national health policy. So as we examine State regulation and its function in the past, we are talking about regulation occurring in the absence of a national health policy. I think that we all anticipate some type of Federal or national health strategy, and we must bear in mind through the course of today's hearings not just State regulation in the context of what was, but State regulation in the context of what is to come.

A word about my personal background, although the chairman summarized it very well. I was North Dakota's elected State insurance commissioner for the preceding 8 years, a position, I might note, now held by my brother. So I continue to track that department's activities very closely. They have gone downhill, might I add. [Laughter.]

I was also privileged to serve the National Association of Insurance Commissioners as vice president in 1989 and president in 1990. In addition, I chaired many task forces on health policy items, including State and Federal health legislative policy task forces. Two roles wherein I interacted with this committee fairly significantly were as the chairman of the Medicare Supplement Task Force and the Long-Term Care Insurance Task Force.

In my comments today, I want to tell you a bit about the structure of State insurance regulation, talk about the context of existing State health insurance regulatory strategies, talk about State regulation within a national health policy, and discuss what I think might be a model for future Federal-State participation in the regulation of health insurance. That model would be the experience we had with Medicare supplement coverages.

State insurance regulation began in the mid-1980s. Its focus, of course, was solvency regulation. I think continuing to the present time, its focus is still solvency regulation. While the GAO report and testimony this morning will reflect critically upon the States' ability to discharge this role, I might note that a review of their track record would show that insurance regulation has, in my opinion, actually fared the best of the financial services industries relative to solvency failures. This reflects, I think, that this responsibility has not been discharged in an entirely incompetent manner.

The States have closely coordinated their approaches, recognizing that the States have undertaken something unique: State regulation of a national commerce—the insurance industry.

In 1871, nearly 20 years before North Dakota became a State, the States joined together to form the National Association of Insurance Commissioners (NAIC). This serves as an entity for the States to closely coordinate their regulatory activities. There are quarterly meetings of the 50 commissioners, as well as many other meetings of task forces for the regulators to focus on specific problems and issues.

As I mentioned, the primary historic thrust of insurance regulation has been solvency. But over the last 30 years, we have seen an increasing trend to regulate market conduct and, to a degree, involving State insurance regulation in social policy issues. And I would say that this is a trend that continues to emerge at present.

The NAIC as a coordinating entity, I believe, is unique in terms of State government associations. It operates with an annual budget of $25 million. It has in its employ probably in excess of 200 individuals now. They facilitate the work of the many task forces but, in addition, provide a level of centralized solvency analysis and other support functions for the States.

Operating as I did in North Dakota with responsibility for regulating a $1 billion industry with a staff that began in the 20s and now numbers about 40, it would have been very difficult for me to discharge these functions without the support of the National Association of Insurance Commissioners.

Within the health insurance industry, there are many different subsets, and I think we have to note the distinctions in regulatory treatment as we talk about various components of the health insurance industry. There are, of course, the self-funded employer groups authorized under ERISA, a 1974 congressional act. As is

mentioned in the GAO testimony, this is strictly outside the purview of State insurance regulation, but for a bit of solvency and antifraud activity permitted for multiple employer welfare arrangements, small employer groups that might band together for self-insurance purposes.

There is employer group coverage, health insurance coverage sold within the private insurance market. Traditionally, health insurance regulation has allowed some leeway in this area, recognizing that the employers were very well suited to cutting their best arrangement within the insurance marketplace. Consequently, we have not had quite as hands-on regulation of employer group coverage as we have had with the individual coverage. Within the individual coverage, there are another two subsets: the senior citizen market, including therein Medicare supplement coverages and long-term care insurance coverage, and those products marketed to individuals, including limited benefit products.

The ERISA experience, I think, indicates that there can be shortcomings when State regulatory activity is preempted on a wholesale basis. We have had an unfortunate amount of fraud and insolvency activity, particularly concerning those groupings of small employers into multiple employer welfare arrangements. States were, in fact, given back some authority in this area because of the problems occurring in a totally unregulated environment.

We have to understand when we look at the ERISA area that it certainly cannot be said that the U.S. Labor Department has actively stepped in to regulate what the States have been preempted from regulating. This has left individuals insured under these self-insurance arrangements without even the benefit of an unfair claims practice act. So if a claim isn't paid when they think it ought to be, they really have no resource to turn to. I think this is an unfortunate attribute of the preemption that came along with the ERISA legislation.

GAO indicates that about 25 percent of the individuals covered by insurance are subject to State insurance regulation for health insurance after adjusting for individuals covered under ERISA plans or those who chose to pay for their own care or are unable to obtain coverage.

While traditionally, as I mentioned, the States have given some leeway to the employer group market, increasingly the States have begun more active regulatory intervention, particularly to address abuses in rating formulas and other unfortunate risk-segmenting activities occurring in the market that have had the effect of unfair trade practices in the small employer group market.

In the senior citizen area, we have basically a consumer population, more fragile, more susceptible to abuse, and as a result, we have had a much more active pattern of State insurance regulatory activity. Sometimes this regulatory activity includes oversight of rates, forms, and the market activities of the companies.

There has been within this marketplace varying levels of interaction with the Federal Government. In certain areas, like long-term care insurance, to date there has not been articulated Federal standards for long-term care insurance and the market conduct therein, but there has been considerable Federal interest. I think

the inquiries and the oversight of the Federal Government has had a helpful role in pushing State regulatory activity along.

In other areas, such as the Medicare supplement market, we have had a whole pattern of minimum Federal standards, and the States have been left to execute what is prescribed as regulatory policy in Federal statute.

The State compliance in this area, as I will elaborate on in a moment, has been, in my opinion, very thorough and conscientious in executing the assigned regulatory responsibilities.

There are limits on State insurance regulation in the health area. I think that insurance regulators are technicians. They are not social engineers. As we grapple with how to solve the incredibly difficult health problems in this country, including health insurance coverage problems, it is appropriate, I believe, that the executive branch and the legislative branch design a national policy and socially engineer our way out of this terrible fix that we are in. This is a challenge far beyond the purview of State insurance regulation, which is focused on primarily solvency and market conduct activities.

Nonetheless, I think that we have seen, probably by default due to the absence of a Federal policy direction, very interesting things occurring at the State level. This reinforces the State role as an innovator and incubator of positive public policy advances. And I think that that has occurred in many instances in a concerted effort by Governors, legislators, and State insurance commissioners as they attempt to address the critical health insurance problems in their States.

I would note that there have been areas of State health insurance activity that have been dysfunctional and have not been exactly helpful. I would cite areas including mandated benefits passed in the legislature more on the strength of a provider group, rather than a deliberation of whether, indeed, the coverage is absolutely critical to a sound health insurance policy; and more recently, a disturbing trend to interfere with managed care. Restrictions on utilization review and other interventionist types of statutes that are pushed, again, by the medical provider community, are dysfunctional health insurance regulation and something that is potentially problematic in that we are trying to get more cost-effective health care and health care reimbursement strategies.

I think that the pattern of State insurance regulation, as noted in the GAO study, reflects a wide variety of philosophical approaches to health insurance regulation. If I might say a word critical of the GAO analysis, I don't think that GAO seems to hold insurance regulators to a benchmark as if they were approaching this problem in a similar strategy. The States have very, very different strategies reflecting very different local circumstances and conditions. And I think that the variations presently seen at the State level should not necessarily support a conclusion that the States cannot respond to a defined national regulatory role should it be spelled out in statute.

In fact, in the Medicare supplement area, this is exactly what the States and the Federal Government have undertaken.

During the years I was insurance commissioner, in 1988, 1989, and 1990, the Federal standards imposed upon the States and the

National Association of Insurance Commissioners changed in terms of how we ought to regulate the Medicare supplement insurance market. First there was passage of the Medicare Catastrophic Care Act, then there was the unsightly debacle of Chairman Rostenkowski being chased down the street by the irate senior citizens; and then there was the repeal of the catastrophic legislation. And then there was, in fact——

Chairman STARK. We do not like to rehash that very much in this committee. [Laughter.]

Mr. POMEROY. I didn't mention the name of the legislation, Chairman Stark.

Mr. THOMAS. For those of us who were not going up the hill and not coming down the hill, I will extend any amount of time you want. [Laughter.]

Mr. POMEROY. In point of fact, I, watching on the sidelines, did not believe enactment of catastrophic legislation was a bad idea. I did think its complete repeal 1 year later was a bad idea, but that is beside the point. No one was asking my opinion at that point.

But what we were doing was rewriting the minimum standards at every stage of the game, and under the catastrophic legislation environment we had a totally different Medicare supplement market. So we changed all the rules, and all the States enacted them. I believe within 1 year 49 of the 50 States changed their regulatory format for Medicare supplement. Then we repealed it. We did the same thing in reverse, except we added federally mandated consumer protection standards, thereby substantially enhancing the consumer protections for senior citizens. And again all of the States quickly enacted this framework.

In 1990, however, a different approach was taken and there was a decision at the Federal level. Congress specifically decided that they wanted to approach a regulatory strategy in Medicare supplement that included 10 standardized policy designs.

The National Association of Insurance Commissioners was given the responsibility to develop each of those policy designs and make sure that they got implemented nationwide. I, in fact, chaired the committee that did get those policy designs developed, and all of the States have either now been certified in compliance or, as I understand it, are certifiable in compliance with this Federal regulation. Again, this is an area where there is a clear Federal direction and 100 percent State participation in following through with the responsibilities allocated to that area.

You might think the GAO doing this study at this point in time might have contemplated or considered something about the Medicare supplement experience, but you will not find a word of it in the report before you. This is unfortunately typical from my experience of GAO reports. Back when I was a State regulator, I kind of thought GAO stood for "Get After Others." The report, to paraphrase an old song: the GAO, "where always is heard a disparaging word."

In their review of State insurance regulation, I believe that a common thread has been to put the most negative spin possible on the regulatory activities underway. And it really has disturbed me that while State insurance regulation is far from perfect—in fact, it should be mentioned that no regulatory system is perfect—there

have been some accomplishments. Yet, you will not find them reflected to any degree in any of the GAO reports that I am familiar with concerning State insurance regulation.

In the final analysis, Mr. Chairman and committee members, I believe that you will see across this country and across the political spectrum a desire for some State flexibility as we administer a national health policy. I have a real belief that Bismarck, N.D., might know a little bit more about the specifics of what we need for a North Dakota health plan than Washington, D.C. That was my belief as insurance commissioner. It is certainly my belief as a Member of Congress.

So I believe State flexibility ought to be in the plan. I am pleased with the reports I am hearing that there will be some allowance for State flexibility. But there is a flip side to the coin. Where there is State flexibility, there must be State responsibility and accountability. The States cannot on the one hand ask for some license and then on the other hand use that as an excuse to do nothing—either in the face of strong provider opposition or insurance company opposition or what have you.

So I think that as we look at approaching this in the future, we ought to have a clear Federal direction of what we expect from the States—standards, if you will—and an ability to monitor and, in fact, preempt State action if the threshold levels of activity are not brought forward at the State level.

That concludes my comments and thoughts, Mr. Chairman. I would be happy to take any questions.

Chairman STARK. Would you have the time to vote? I have been advised that we have a journal vote. Would you be able to vote and come back?

Mr. POMEROY. Of course.

Chairman STARK. OK. Why don't we recess for 10 minutes?

[Recess.]

Chairman STARK. Earl, thank you.

We have gone through a lot of this together, and let me make some comments to set the stage for my rhetorical question to which I would like you to respond. There have been a couple problems that we have seen not necessarily as the result of the State regulator, but as the State regulator relates to the State executive and the State legislature. And I think it is fair to say that in some cases the legislatures have refused to give the regulators the authority that they feel they need to do their job.

I don't mean to blame that on regulators. I just suggest that that, in fact, is one area. The other is we still have some NAIC model laws and regulations that your group agreed to, that Congress supports, but I think there are still some States that just haven't passed them. Whether they are not going to pass them or can't pass them, I think it is a fact that they haven't come along and done it.

So I would like to suggest that State regulators by themselves are certainly not to be considered the problem, but in the context of the whole State approach to regulation, their problems may not be with us or they may be more in tune with the State.

In defense, I guess, or in clarification—I don't really feel the GAO needs any defense—I don't suppose there is anybody in here

who has been audited more than I have for one reason or another. None, I might add, of which has resulted in indictments, but the fact is that auditors don't give a better grade than zero. They do not give positive grades, whether it is CPAs or tax auditors. You don't get a grade between 1 and 100; you just don't go to jail. The only comments you may get are why you didn't pass or what you didn't do right. It is like the difference between analyzing a bond, which is either safe, you are going to get your money back or you are not, unlike a stock, where you anticipate getting your money back up to 1, 10, 100 times more.

They are very dour, dry, skeptical people, and they are not there to hand out brownie points. They are there to point out everything bad, and they really aren't paid to point out anything good.

Now, I am sure in their heart of hearts they find much that they would like to compliment people on, but if they can't certify it, they are not apt to do it.

So I say that I have never looked at a GAO report expecting to see much of an accolade. It would be a very short report. I just add that for what it is worth.

I am sure that you are familiar, as the members of the committee are, with the idea of HIPCs, as a new form of entity, indeed almost a new form of regulation, if not a new form of a cooperative society or insuring institution. I don't think it makes much difference. But we all generally have this idea of what they have in mind.

In California, if you think of HMOs, which are almost as foreign in certain States in this country as HIPCs are in every State in this country, we have three different groups regulating them. The California Department of Corporations, which my colleague from California knows, doesn't have but a half a dozen employees. It is supposed to regulate HMOs, which are legion and have millions of people as their beneficiaries.

Now, they, I suppose, look after solvency, although that is unclear. On the other hand, the people from the Medicare standpoint aren't very much at risk. The HMO goes broke, and they could transfer to any other place they want, and their insurance is good someplace else. They have lost their opportunity for medigap, except that now it is open enrollment under our rules. So basically our position is, what do you care if Kaiser goes broke? So they go broke? Somebody else will step in and pick up the flag and lead the charge.

Nonetheless, I expect the experience we have had in Florida and southern California, where a lot of providers were stuck with bad debts, it is in the public interest there. But we have the corporation commission.

Then we have the insurance commissioner insofar as some of these plans have some part of insurance, some actuarial predictions and reserves for the future. They regulate whatever they determine is the insurance aspect of it.

Then the third group that comes in is the Department of Health which deals with quality. I am just suggesting that the other 49 States may very well be every bit as creative as California, and they are entitled to do that. And, again, if the Congress and the President weren't planning, I believe, to offer everybody in the

country some kind of coverage and access, we are suddenly going to be dealing with, let's say, 30 or 40 million people who aren't now in the system. And they most likely be connected with one of these regulated issues.

You touched on it, and I guess this is what the hearing is about. Just in terms of staff, how in the State of California can a half dozen guys in the corporation commission just take care of the business they have, and then go about regulating virtually a program that would have to have 12 million people in it dealing with 20 to 50 different providers? It is kind of a big task.

The issue here is: How much can you, as you suggest, delegate? How uniform ought the regulations to be from State to State? And there I would ask you to dwell on where we are today. We are in the District of Columbia, and we are very close to Maryland and Virginia. About half the people in this room live in one of those jurisdictions and work in another. Each one has an insurance commissioner, and each one, unless there is one universal HIPC, might have a different HIPC where the employer is here and the provider is in Virginia. There we almost, it seems to me, of necessity would have to have absolute uniformity in how we regulate those.

So my question is: Is there a prescribed area? And I think my feeling would be in the area of insurability, solvency where they do it in other States. I would be more comfortable in California, quite frankly, if the solvency issue, which I think in the insurance area is merely the integrity of assets. I don't really see other issues. You get into reserves in terms of casualty and life, but in health it is so short that usually it is 3 months, at most a year, and standard reserving techniques don't apply.

Do you think that we could write into law that you could overlay for each State if, in fact, we were going to authorize, mandate HIPCs? If we mandate the HIPCs, ought we not give a set of guidelines to each State for regulations? I don't care whether it is the insurance commissioner or a corporation commissioner. But if they didn't perform, the Federal Government would, in fact, have to do the regulating for them.

That is a long-winded kind of approach, but those are the concerns I think that are going to hit us.

Mr. POMEROY. Mr. Chairman, I think that approach makes sense to me. I reserve final judgment until getting a chance to see this plan, when we finally get it, and contemplate it a bit.

It seems to me a national health strategy is going to go one of two ways. A Federal provider of coverage and maybe care would require an enormous administrative structure. That would have to be developed. That does not appear to be what is likely to be coming out of the White House. This private-based national health reform package will therefore require a substantial amount of attention on regulating the private execution of those areas reserved for the private sector.

It is going to be different from what we have known, so I do not think you would want to just leave it to develop wholly autonomously at the State level. I think there will need to be some guidance and direction given to State regulatory jurisdictions, and even more fundamentally than that, assess what is appropriate for the

States versus a new Federal regulatory presence in this national health plan.

I believe that State flexibility ought to be included. That ought to include a State regulatory role, and I do not have any objections to notions of defined role and expectations prescribed in the Federal Government with, in fact, a preemptive alternative in the event that the States do not provide that threshold activity within a reasonable period of time.

I have learned that it is very dangerous to specify timeframes.

Chairman STARK. Thank you.

Mr. POMEROY. Thank you, Mr. Chairman.

Chairman STARK. Really that is the answer I was fishing for.

Mr. Thomas.

Mr. THOMAS. Thank you very much, Mr. Chairman.

Those of us who are in pursuit of a solution to however we define health care problems I think would have looked to the advice of the Chairman of the National Economic Advisers of the President, the Secretary of the Treasury, and the Director of the Office of Management and Budget, and they recommended to the President that a phasein through the year 2000 was the appropriate plan to take if you are looking to solve a quote, unquote problem.

When you want to do it by—oh, pick a date—June 1996? There may be other reasons driving that timetable other than solving the health problems.

And so all of us share a concern in which a timeframe is selected for what would otherwise be extraneous reasons for solving the health care problem.

Mr. Pomeroy, I appreciate your versatility. We do not often have members who so quickly, first of all, cross the line. I think that is a real plus, because you are now offering not only the insights that you had out in the field on this very subject matter and testifying on one side of the fence, but you are on the other, and you can counsel us in ways that perhaps you were constrained from counseling us in the past and share with us your personal observations and not just those that you have been instructed to present as someone representing a very broad conglomeration of diverse States.

My concern is that when you start talking about whether or not States are able to perform certain tasks and you rely on studies that supposedly are supposed to provide you with criteria to determine performance of a State or the capability of a State to perform, that you had better tread fairly lightly in making assumptions. You had better make sure that you have a very rigorous methodology that would be subject to challenge to determine whether or not your assessment of a State's performance or capacity or capability was, in fact, adequately measured.

And I think, based upon some of the statements that you made earlier, that you might share my concern about the GAO study. In reading it, I did not find any real ability to determine from the work that they had done a performance capability level of States or the capacity of States to perform particular functions.

Would you generally agree with that in terms of the GAO study?

Mr. POMEROY. I would generally agree with that. I think that clearly the GAO is assigned a number of studies, and they invent

other studies that they then undertake. Undoubtedly it stretches their resources, although their resources are considerable.

I believe sometimes there has perhaps not been a sufficient sensitivity at GAO that a GAO report carries very substantial weight by virtue of what it is held forth to offer. Therefore they need to be extremely careful about the methodology wherein they take their studies, so that, in fact, conclusions that are drawn from their reports are reasonably supported by the data.

Mr. THOMAS. I would think that that would be a fundamental, when you draw conclusions from a report, that there be some substantiation within the report for those conclusions.

Mr. POMEROY. Yes, but——

Mr. THOMAS. I had hoped we could have tasked them at a slightly higher, more professional level, but I agree with you completely that in the GAO studies I have seen, you cannot even deal with it at that level.

The other concern I have is that if they carry out some kind of accounting procedure against model statutes that had been constructed. How in the world, in your opinion, can you compare the number of States who have complied with some model statute put out by a voluntary association with whether or not a State will have the performance or capacity to carry out a task assigned to it by the Federal Government? Is there any way to compare or contrast that information?

Mr. POMEROY. There is no way to compare or contrast that. Model laws are not necessarily intended to be uniform laws. And adoption right across the 50 States was in many cases—I would say most cases—never anticipated by the NAIC in placing the model stamp on a given regulatory proposal.

Mr. THOMAS. And so when the chairman, I think quite rightly, identified GAO by primarily its middle name—that it is accounting; that it is not some kind of a behavioral studying structure. The models that they tend to use perhaps should be more akin to auditing and debits and assets and that sort of thing. Perhaps it is partly our fault, because we assume that we want them to, and therefore we assume that they tend to carry out studies assessing performance and capacity to a certain extent when perhaps it is beyond their structural capability, or we have failed to task them in the proper way in terms of whether or not they could carry out a study with the proper parameters and assumptions to truly determine whether or not performance and capacity can be measured by virtue of the study that they make.

Do you think it is inherent in the GAO structure, or do you think it is more the way in which they are tasked without a clear understanding of what needs to be done on what I would consider to be any normal professional behavioral study with the posited assumption, hypothesis, and then determining if conclusions can be drawn accurately from it?

Mr. POMEROY. Let me acknowledge a personal perspective, as one who has been at the receiving end of these audits, and I will acknowledge some truth in what the chairman says. An audit is not likely to be flattering. And so I may have my perception here a little skewed by personal experience.

But I believe that there are times that more of a——

Mr. THOMAS. If the gentleman will allow me, that is a danger that frankly more Members of Congress ought to be exposed to. So I am looking forward to what you say.

Mr. POMEROY. Thank you. I believe at times there is a tendency in the GAO's execution of a report request, rather than be entirely arms-length and objective when researching the assigned topic, to have more like a law clerk/senior partner relationship where off they run and try to give the report that they suspect has been requested.

I think that if reports are not very carefully monitored within GAO for quality assurance in the execution of their studies over time, that this is going to undercut the credibility of their agency and, in fact, already has.

Mr. THOMAS. And then just let me say that if, in fact, this is supposed to be a contest between determining a State's capacity to carry out some of the tasks that may be assigned to it in the health care reform program versus the assumed desirable opposite, which is the Federal Government's uniform control over 50 States. I just wonder what the GAO study would look like in terms of the evaluation of the Federal Government in terms of its success in assigning a single uniform benefit plan and price across the United States, a single required relationship between provider and patient, a single required relationship between doctors, hospitals, employers, employees, when all of the indicators are that people place fundamental, in terms of any changes, flexibility, and choice and that we haven't had any study which truly evaluates an alternative, if what you are attempting to do is to trash a State's ability to play a particular role in a system without looking at the alternative, but simply assuming that the only thing you can do is move to the alternative, which is a uniform assignment from the Federal Government to reach across all States.

Mr. POMEROY. Well, a GAO study typically is not a comparative instrument, and that is unfortunate, because it is then used in the public domain, as you mentioned, trashing a given component without really weighing the alternatives.

No system is perfect, and let me emphasize that the North Dakota Insurance Department, while I was commissioner, was not perfect, and the State insurance regulatory activity was not perfect. But I think that it is better as a functioning regulatory system than some of the exclusively Federal alternatives.

Mr. THOMAS. So in conclusion, when we have in front of us a study titled "Private Health Insurance: A Wide Variation in State Insurance Departments' Regulatory Authority, Oversight, and Resources", what would be the best way that you would sum up the value of this material in attempting to make a decision as to whether or not we ought to task from the Federal level, with some uniform requirements and behavioral models, a role for the States in whatever new form we may have? Is this a useful document to guide us?

Mr. POMEROY. No. I believe it is a worthless document. This document is a——

Mr. THOMAS. Let the record show that I was not attempting to lead the witness. [Laughter.]

Mr. POMEROY. This document is a historic look at State regulatory activity, discharged under questionably effective study techniques that do not contemplate a national health plan undertaken by this country.

Mr. THOMAS. I thank the gentleman, because I know that some of the statements may be, you know, in part difficult to make because of the need to deal with relationships in your new position, but I really appreciate your honesty and forthrightness, because we are looking to solve problems.

I am not looking to June of 1996 to solve it. I am looking to the resources of the United States and its people to solve the problem. And I cannot believe that someone does not believe that there is a valuable resource in the States in a role in terms of a new health program.

And I thank the gentleman very much.

Mr. POMEROY. Thank you, Mr. Thomas. I have about 60,000 uninsured North Dakotans that I represent, and the only timetable they are thinking about is getting them coverage in a meaningful way just as fast as possible, and many of the nuances we wrestle with are of very little concern to them. They want something done fast.

I might also add that the chairman and I have enjoyed a lively dialog on these topics over the past several years, and the chairman did extend his invitation for me to testify here today. I know that the chairman contemplated candor, and I appreciate very much the chairman's invitation to share my observations.

Chairman STARK. Mr. Grandy.

Mr. GRANDY. Well, gee whiz, Mr. Chairman, if the document is worthless, there is not much to talk about, then. [Laughter.] What is your favorite color, Earl? [Laughter.] Are you going to do some Norwegian jokes while you are here? [Laughter.] Well, I guess what I will have to do—and, of course, I am a big supporter of GAO studies; we used one in the bank scandal. [Laughter.] But who cares? Those guys are not in Congress.

Let me fall back on your expertise as a former commissioner, which I must say in all seriousness that your testimony was far more illuminating than the study, and because of that, I want to get some of your thoughts about the whole relationship between State flexibility and the Federal Government's role when we get to a grand design for health care reform.

One of the sticking points, at least on our side of the aisle, has been how do you reconcile federally decided and legislated global budgets on an annual basis with State flexibility for delivery of the product and determination of benefits?

Do you have any thoughts on how you put together a kind of Federal budget, whether it is price controls or a global budget or both, and then pass back the responsibilities of administration and supposedly creation and innovation at the State level? I mean, is one in competition with the other, or is there a way to put them together to make an effective solution?

You talked about the demographics in Bismarck probably being a little different than they are in the greater Washington area. I would have to agree with that.

How do you do that, then? I mean, if you have a Federal budget, if you have a global budget, if you have price controls, are you so hamstrung at the State level that you cannot implement a product that will be advantageous to your constituents, particularly the 60,000 that do not have anything, or is there a way to put those two concepts together?

Mr. POMEROY. Mr. Grandy, I believe there is a way to put those two concepts together. I have reluctantly concluded that competition alone cannot be anticipated to hold down costs because the relative competitiveness of the health insurance market varies greatly across the country.

In the Twin Cities, not far from North Dakota, we see Minneapolis/St. Paul, a dynamic marketplace driven by large employer competition that has pushed HMO financing and care delivery to the forefront.

Just 300 miles to the west, you get North Dakota, where you do not have the presence of large employers. You do not have any HMO medical care delivery and financing to speak of. And you really do not have the competitive forces that in metropolitan areas have had a tendency to force the system into more cost-effective care delivery. And so, then, in a system like North Dakota, you have very ineffective, very inefficient, from a cost standpoint, care delivery. High-quality care, but very expensive.

I think, therefore, that when you do not have the large employer presence representing a major purchasing entity of health insurance services and therefore requiring more cost-effective care delivery, you do need a governmental intervention of some sort.

Looking across the country, while there are areas of substantial State innovation, there are perhaps a greater number of areas where the States clearly can use some help, and I think that is the case in North Dakota.

I look for a Federal plan, therefore, that does help where competition is not driving care delivery to more cost-effective vehicles, a Federal system, including a greater governmental role, to push the system in that direction.

Mr. GRANDY. In that Federal system, do you see a new redefined role for multiemployer welfare arrangements or multiemployer health care arrangements, whatever we want to call them, mindful, of course, that they have a bad reputation based on some of the abuses that they have been rightly accused of?

It has been my experience, first as a member of the Education and Labor Committee, which has jurisdiction over MEWAs, and now this committee, that there is a potential for pooling among these multiemployer welfare arrangements. But the regulation has been shoddy and somewhat slapdash, and it seems to me there is probably, if they are going to exist, a Federal oversight role on some of these smaller pooling mechanism, which I think, at least in some of the communities I represent, would be perhaps a more popular choice than a large HIPC or purchasing organization.

Do you agree?

Mr. POMEROY. No, I do not necessarily agree. In coming from a district where you would virtually describe 99 percent of the employers as small employers, I am intrigued by the concept of a purchasing cooperative, including providing some staffing and support

services and data collection, which will allow the employers within this collective purchasing arrangement to make a level of purchasing decisions that is more sophisticated and better serves their needs than they have been able to do otherwise, mostly with the multiple-employer welfare arrangements. I believe those arrangements are strung together by promoters of a health insurance pool, and as we have seen and as you noted, those promoters have not always been ethical, causing a lot of trouble in that area.

I think a larger, better supported collective purchasing arrangement might be a positive development.

Mr. GRANDY. So in other words, what you would do is incorporate the MEWA into the larger pooling mechanism.

Mr. POMEROY. Yes, I would.

Mr. GRANDY. Let me see if I can follow that. Assuming that you would weed out all the unscrupulous promoters if you had a larger entity that was controlling more of the market, there would be less chance for mischief if you have some of these guys operating at the margins precluded from getting in?

Mr. POMEROY. That is my belief.

Mr. GRANDY. Well, I guess I would have to say—and this may be just a parochial comment, because as you may be aware, there is a rather substantive insurance industry in the State of Iowa, and not all of these guys are necessarily promoters—I would hope that when we get to some kind of determination of what the Federal role is, there is opportunity for large and small.

I see the need for oversight, because there clearly have been MEWAs that have been set up to grab premiums and not provide benefits, and they have been insolvent, and they have been nothing more than scams.

But that is not to say that the concept itself, I think, is flawed. I think the oversight has been flawed. I think to some degree it was impossible for States to regulate them because they moved around so much.

But I would hope that under some kind of Federal omnibus plan, there would be a potential for smaller communities that perhaps might not want to latch onto something that is run by one of the Big Five, to perhaps form their own purchasing agreement, even if it went up and down the Main Streets of towns, the likes of which you normally represent. I mean, I assume you and I have a similar district, in that your biggest town is what, Bismarck?

Mr. POMEROY. Fargo.

Mr. GRANDY. Fargo, OK. My biggest town is Sioux City. They are roughly about the same size. Normally your communities are somewhere between 2,500 and less; is that not true?

Mr. POMEROY. Yes.

Mr. GRANDY. Well, I would hope that there would be some kind of possibility that some of these smaller communities could be allowed to band together rather than necessarily have to latch onto the great purchasing organizations that I think will grow out of this thing.

I guess I have some concerns as to what is the difference in regulation if you just move from public sector regulation to huge private sector regulated entities?

I keep thinking of the railroads when I think about this. You are going to wind up with captive shippers, no matter what.

Mr. POMEROY. That is a frightening prospect. [Laughter.]

I have high regard for the Iowa insurance industry. They are not principally involved in the business of MEWA promotion, I assure you.

Mr. GRANDY. I know that.

Mr. POMEROY. I look forward to having the White House health plan before us and think these discussions will be much more productive when we have a clear proposal.

Over the last several years, I have been involved in a variety of hearings, seminars, discussions. Without focused leadership, health care in this country really has not gone anywhere. I think that undoubtedly there will be much in this plan to question and pick apart, but at least we will have a starting point for our discussions, and we will have the emerging national health policy underway. I think that that will be a very substantial development and make discussions like this much more productive.

Mr. GRANDY. Well, I look forward to those discussions.

Thank you, Mr. Chairman.

Chairman STARK. Thank you. Earl, thank you very much.

Mr. POMEROY. Thank you very much, Mr. Chairman.

Chairman STARK. The committee will recess for about 3 minutes, and we will give the next witnesses time to don their bulletproof vests and timidly approach the witness table. [Laughter.]

[Recess.]

Chairman STARK. The committee will reconvene.

I would like to welcome Leslie Aronovitz, Associate Director of Health Financing Issues of the Human Resources Division of the U.S. General Accounting Office, John C. Hansen, Assistant Director of Health Financing and Policy Issues, and Paul Alcocer, Senior Evaluator of the Denver Regional Office.

It is my intention to see that by the close of business today, Ms. Aronovitz, you receive a copy of the testimony relating to the previous witness.

I am not sure the accuracy was questioned. It may have been conclusions, but, again, I would like to have you have that opportunity. I know it is the policy of the GAO, when any of our entities are criticized or indeed when any outside private organizations come under your purview, they are given a chance to respond, and it would seem to me what is sauce for the goose ought to be sauce for the gander.

I am inclined to think, to the extent my opinion makes any difference, that the insurance regulators of the 50 States of the United States are handmaidens of the insurance companies and have not prevented some of the most disastrous regulatory failures leading to the loss of pensions for many thousands of employees in California, the demise of several major life insurance companies, causing untold loss of jobs and loss of financial savings. Indeed, the Congress and administration have failed, it seems to me, to raise that issue.

I would precede your testimony with a question. I don't know whether any of you can answer it. The Chair would submit the proposition that if the life insurance industry in this country today

had to mark their investment portfolios to market, they would all be bankrupt, and that is something that in my opinion is an impeachment of every insurance regulator in this country, not to call attention to the consumers of this country who are being arguably hoodwinked into investing their money in corporations that are totally unsafe by any financial standards. And for anybody to criticize the General Accounting Office for being somewhat harsh on a group who have failed to perform their duties with such dereliction of duty somehow doesn't seem appropriate.

Are any of you willing individually to indicate whether or not there is any information supporting the Chair's statement that, in his opinion, most insurance companies would be bankrupt, if they had to value their investments as we do?

STATEMENT OF LESLIE G. ARONOVITZ, ASSOCIATE DIRECTOR, HEALTH FINANCING ISSUES, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY JOHN C. HANSEN, ASSISTANT DIRECTOR, HEALTH FINANCING AND POLICY ISSUES; PAUL D. ALCOCER, SENIOR EVALUATOR, DENVER REGIONAL OFFICE, AND LARRY CLUFF, ASSISTANT DIRECTOR, ECONOMIC ANALYSIS GROUP AND INSURANCE ISSUES, GENERAL GOVERNMENT DIVISION

Ms. ARONOVITZ. Mr. Chairman, before I answer, I would like to first introduce to you the gentleman on my far right. His name is Larry Cluff, and he has managed our insurance work for many years. He is in a different part of our organization, and he can comment on your question.

Chairman STARK. Please.

Mr. CLUFF. Mr. Chairman, thank you for the opportunity to be here today.

I would answer your question by saying that no one knows the answer to your question, including the State insurance regulators, because the State regulators do not ask for the information that would allow them to answer that question. In fact, information is provided by insurance companies in a way that obscures the true underlying value of the assets that are held by insurance companies, and, therefore, it is not possible to know the answer. It is not unreasonable, however, to believe that some companies would be insolvent on a market value basis.

Chairman STARK. Let's try one more. If you knew, and I suspect you could ascertain, what the value, say, of a class of assets—let's just take, for example, real estate or real estate loans—were 5 years ago, would it take a rocket scientist to make a conservative estimate that those same assets might have depreciated by 10, 20, 30 percent, assuming that they were not so unique as to have the only few good real estate assets left in the country? Are there some broad-gauge assumptions that might be made?

Mr. CLUFF. I believe that everyone is aware of what has happened to real estate markets in the country, sir.

Chairman STARK. And so it would not take, again, a great deal of deciphering to figure out that if 20 percent of the total assets of a life insurance company were in real estate, and that real estate on average had dropped, let's be generous and say, 25 percent, that the value of the assets of that company were down 5 percent. If

their capital wasn't 5 percent, they would be pretty close to insolvency, wouldn't they?

Mr. CLUFF. That seems a reasonable calculation, sir.

Chairman STARK. But you are saying the insurance commissioners don't make that?

Mr. CLUFF. No, sir, I do not believe they do, in general.

Chairman STARK. Well, so much for the security of the rock.

With that, why don't you proceed. Your tarnished testimony will appear in the record in its entirety. Why don't you proceed to enlighten me or defend your good department in any manner that you are comfortable, Ms. Aronovitz.

Ms. ARONOVITZ. Thank you very much.

We are pleased to be here today [laughter] to discuss the results of our survey on how State insurance departments regulate health insurance, the resources they commit to these efforts, and the implications health care reform could have on their regulatory roles and responsibilities.

Mr. Chairman, I feel obliged to immediately respond to the concerns expressed about our study, but I will proceed to talk about our survey results, with the reassurance that the scope of our study will be clarified later in this hearing, and we will obtain the transcript at a later date and respond to it.

State insurance departments have played an important role in previous State efforts to address problems with the cost and availability of health insurance. Because most national health care reform proposals include provisions that could fundamentally change the health insurance marketplace, States and their insurance departments could play a large role in enforcing new requirements, should any of these proposals be adopted.

In our study, we determined the portion of the health insurance market that is regulated by State insurance departments. We will report baseline data on department standards, regulatory responsibilities, budget and staff resources committed to regulating health insurance, and will point out the key activities that they perform.

To address these issues, we conducted a questionnaire survey of the 50 State insurance departments and the District of Columbia. We received responses from every State except Mississippi, and visited insurance department officials in seven States. Those were California, Colorado, Illinois, New York, Texas, Vermont, and Virginia.

Although the departments are responsible for overseeing health insurers and protecting consumers, their authority extends only over a part of the market. Also, we found that their role in health insurance regulation is affected by their legal framework and business regulation philosophy.

Finally, the resources State legislatures allocate to their insurance departments and the proportion the department dedicates to regulating health insurance vary widely among States.

About 34 percent of the Nation's health expenditures are paid for out of pocket by individuals or through self-insured employer health plans. Today, self-insured plans regulated under ERISA cover about half of all U.S. workers. Also, about 42 percent of health care is funded and regulated at the Federal level through programs such as Medicare and CHAMPUS, and jointly by Federal

and State agencies for programs such as Medicaid. Therefore, only about 24 percent of health care is paid for by private health insurance that is regulated by State insurance departments.

To carry out their regulatory responsibilities, insurance departments estimated that in 1991, they devoted about 24 percent of their 1991 resources, on average, to regulating health insurance. This is just an estimate. It is a soft number that is very difficult to determine, because State insurance departments are not organized in a way that groups the health regulation activities all in one place.

We also found that estimates of individual resource commitments varied widely among the different States, ranging from 4 to 57 percent of their overall insurance regulatory budgets. In terms of staff, the 28 States that could answer our survey questionnaire estimated that the number devoted to regulating health insurance ranged from 1 full-time equivalent to 153, with a median of about 18 staff members. Some 22 States could not answer the question, primarily because of the way their insurance departments are organized.

States try to protect consumers through a variety of regulatory activities. They monitor the financial solvency of companies, they perform rate and policy form reviews, and they investigate consumer complaints. Those are the main functions.

With regard to monitoring solvency, we found that the number of health insurer failures nationwide has increased since the mid-1980s, and when this happens, the results can be catastrophic. State insurance departments responding to our survey reported that in 1991 they liquidated 46 companies. These were predominantly in four States, Illinois, Louisiana, Pennsylvania, and Texas. Officials told us that the six companies that were liquidated in Texas had insured over 20,000 residents. They could not determine for us how many of these people could not get other health insurance based on a preexisting condition or the cost of the health insurance.

Past GAO work has also raised serious questions about the effectiveness of States' efforts to monitor insurer solvency. This will continue to be a major challenge for the States, whether there is health reform or not.

In regard to other insurance department key functions, our survey found wide variations in the practices and procedures used to approve premium rates, review policy forms, and handle and investigate consumer complaints.

For example, in approving rates, several insurance departments require detailed rate submissions which must be approved before the rate can be used. Insurance departments in six other States do not routinely receive premium information for first-time rates, and four don't receive it for increases or changes in a rate once a policy is in existence. Several other States require companies to file rates, but do not have the authority to regulate the insurance premiums.

Our study did not make conclusions about the performance of any insurance department. Such an assessment would have required us to obtain criteria for many areas such as States' regulatory framework, the economic climate in the State, and the number of domestic insurers that are in the State. Our comments on

solvency, where we do have some discussion of how well States are working, are based on a vast body of work that we have performed over the last decade.

Also, in the context of this study, we do not advocate any approach to insurance regulation. We are only pointing out that there is a lot of variety in the way States currently regulate health insurance, in their regulatory philosophies, the resources they commit, and the activities that they perform. Therefore, as the Congress analyzes various reform proposals, we believe it needs to consider what role State insurance departments will play in enforcing any new requirements.

A reform plan should clearly specify what State insurance departments are expected to do to carry out their responsibilities. These expectations need to consider the wide variations in State departments' legal authority, regulatory activities and resources, to make sure that whatever States need to do in the future, they have the necessary enforcement tools to carry that out.

That concludes my formal statement. I would be happy to answer any questions that you might have.

[The prepared statement and attachments follow:]

TESTIMONY OF LESLIE G. ARONOVITZ
U.S. GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the results of our survey of how state insurance departments regulate health insurance, the resources they commit to these efforts, and the implications health care reform could have on their regulatory roles and responsibilities.

The rapidly rising cost of health insurance and the growing number of uninsured have pushed the debate over health care reform to the forefront. State insurance departments have played an important role in previous state efforts to address problems with the cost and availability of health insurance. Because most national health care reform proposals include provisions that could fundamentally change the health insurance marketplace, states and their insurance departments could play a large role in enforcing new requirements should any of these proposals be adopted.

In response to concerns about the implications of health care reform on the enforcement roles and responsibilities of state insurance departments, we were asked to determine:

- -- what portion of the health insurance market is regulated by state insurance departments,
- -- the standards state insurance departments follow and the extent of their regulatory responsibilities,
- -- the budget and staff resources state insurance departments commit to regulating health insurance, and
- -- the key activities departments perform, including monitoring solvency, reviewing rate and policy forms and responding to consumer complaints.

To address these issues, we conducted a questionnaire survey of the insurance departments of the 50 states and the District of Columbia,[1] and visited insurance department officials in 7 states--California, Colorado, Illinois, New York, Texas, Vermont and Virginia. We also reviewed model laws, regulations, and guidelines for health insurance regulation developed by the National Association of Insurance Commissioners (NAIC), and interviewed representatives of NAIC and the Health Insurance Association of America.

BACKGROUND

In 1945, the McCarran-Ferguson Act assigned the states primary responsibility for regulating the insurance industry. In general, state legislatures establish the rules under which insurance companies must operate, and state insurance departments enforce these rules.

The major responsibilities of state insurance departments typically include:

- -- Licensing insurance companies and the agents who sell insurance to assure that companies are financially sound and reputable and that agents are qualified.
- -- Setting standards for, and monitoring the financial operations of, insurers to determine whether they have adequate reserves to pay policyholder claims.

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[1]Mississippi did not respond to our questionnaire.

-- Reviewing and approving rates to ensure that they are both reasonable for consumers and sufficient to maintain the solvency of insurance companies.

-- Reviewing and approving insurance policies to make sure that they are not vague or misleading, and assure that they meet state requirements, such as mandatory benefit provisions.

-- Monitoring insurers' actions to make sure that they are not engaging in unfair business practices or otherwise taking advantage of consumers, and assisting consumers by investigating their complaints, answering questions and conducting educational programs.

To encourage uniformity in state approaches to regulation, the state insurance regulators established a national association--NAIC--to help coordinate their activities. NAIC consists of the heads of the insurance departments of the 50 states, the District of Columbia, and four U.S. territories. NAIC develops and adopts model laws and regulations that state insurance commissioners collectively believe are needed to regulate the insurance business. Many states adopt NAIC's models, but NAIC has no authority to require individual states to adopt these models.

STATE INSURANCE DEPARTMENTS' ROLE, AUTHORITY AND RESOURCES FOR REGULATING HEALTH INSURANCE

Although the state insurance departments are responsible for overseeing health insurers and protecting consumers, their authority extends over only part of the market and varies widely among states. Moreover, since the passage of the Employee Retirement Income Security Act of 1974 (ERISA),[2] more and more firms have elected to self-insure their health plans under ERISA, thereby avoiding state regulation.

Each state insurance department's role in health insurance regulation is also affected by its legal framework and business regulation philosophy. The resources state legislatures allocate to their insurance departments and the proportion the department dedicates to regulating health insurance also vary widely among states.

Insurance Departments' Role in Regulating Health Insurance is Limited

State insurance departments' oversight of health insurance coverage is limited to only a portion of the health care expenditures in each state. This is due, in part, to ERISA, which has constrained states' ability to regulate employer-sponsored health plans that choose to self-insure. Although ERISA was designed to correct serious problems with the solvency of employer-funded pension funds, the act also covers all employee welfare benefit plans, which include health and other employee benefits.

While ERISA confirmed the states' authority to regulate insurance companies, it preempted states from regulating self-insured health plans. ERISA's preemption provision enables employee benefit plans to serve employees in many jurisdictions without becoming subject to conflicting and inconsistent laws of the various state and local governments. The ERISA exemption has produced a divided system for regulating health benefits in each

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[2]The Employee Retirement Income Security Act of 1974 (ERISA) established limited federal standards for welfare benefit plans, which include health and other employee benefits. ERISA plans are regulated by the Department of Labor.

state, such that the federal government has authority to regulate self-insured employee health plans, but not health policies sold by insurance companies. Conversely, states can regulate insurance companies and their policies, but not employee health benefit plans provided by employers who self-insure.

About 34 percent of the United States' national health expenditures is paid for out-of-pocket by individuals or through self-insured employer health plans. The self-insured plans, regulated by ERISA, cover over half of all U.S. workers. About 42 percent of health care is funded and regulated by the federal government through programs such as Medicare, and jointly by federal and state agencies for programs such as Medicaid. The remaining 24 percent of health care is paid for by private health insurance that is regulated by state insurance departments.

ERISA's preemption provision has also created regulatory confusion in states' efforts to oversee the use of multiple employer welfare arrangements (MEWAs). In a MEWA, a group of small businesses pool funds as a way to pay for benefits or to buy group insurance at rates that are affordable for their employees. Others have contracted with firms offering health benefits at reduced rates to groups of employers. A 1983 ERISA amendment created dual federal and state authority over MEWAs, thereby enabling states to subject MEWAs to state insurance laws. However, continued confusion about states' regulatory responsibilities has enabled fraudulent MEWAs to delay state enforcement actions by claiming that they are employee benefit plans covered by ERISA. Between January 1988 and June 1991, fraudulent MEWAs left at least 398,000 participants with over $123 million in unpaid health claims, and others without health insurance.

<u>Many States Have Not Adopted NAIC Guidelines for Regulating Health Insurance</u>

Each state maintains its own legal framework for regulating insurance in which the roles and responsibilities for each insurance department may differ. Over the years, NAIC has developed about 200 model laws, regulations and guidelines designed to foster state acceptance of the legal and regulatory authorities necessary to effectively regulate insurance. However, NAIC has no authority to require states to adopt or implement its model policies. This responsibility falls to state legislatures. In some cases, states have not adopted NAIC's models. However, they may have adopted their own law addressing the same issue, which in some cases, may be more stringent than those NAIC recommended.

As of April 1993, many states had not adopted NAIC models addressing health insurance regulation, even though this guidance had been in existence for at least 5 years. For example,

-- 19 states had not adopted NAIC's model regulation that sets authority and standards for identifying insurers whose hazardous financial condition threatens the public or policyholders,

-- 16 states had not adopted NAIC's model on minimum reserve standards for health insurance contracts that establishes how health insurance companies must determine cash reserves for paying future claims,

-- 44 states had not adopted NAIC's model on HMO investments that sets limitations on what HMOs may invest in so that solvency problems from bad investments can be minimized, and

-- 28 states had not adopted NAIC's model minimum standards for individual accident and health insurance designed to

eliminate health insurance policy provisions that are misleading or confusing, and provide reasonable standardization.

<u>Resources Committed to Health Insurance Regulation Vary Widely</u>

State insurance departments are responsible for regulating many different types of insurance. In addition to health insurance, they also regulate other insurance such as life, auto, homeowners and other property and casualty. Thus, their resources are spread over a wide range of insurance products.

Our study found that, on average, the state insurance departments devoted about 24 percent of their 1991 resources to regulating health insurance. However, estimates of individual resource commitments varied widely, ranging from 4 to 57 percent of their budgets. (Appendix I lists state insurance department budgets and the percent devoted to health insurance regulation.)

It is difficult for states to estimate the number of staff that oversee a particular type of insurance because state insurance departments are typically organized by regulatory activity--not line of business. However, 28 states estimated that the number of full time staff[3] expended on regulating health insurance ranged from 1 to 153, with the median number of 18 staff members. Eight of the 28 states estimated that they had less than 10 full time staff involved in regulating health insurance[4], and 22 state insurance departments were not able to provide an estimate of the number of full time staff involved in regulating health insurance. (Appendix II lists the states' total department staff, full time equivalent staff spent on health insurance regulation, and the number of actuaries working on health insurance regulation.)

Actuaries are particularly important employees of insurance departments because of the role they play in estimating future claims payments. Based on these estimates, they are able to judge the adequacy of an insurers loss reserves. They can also review an insurer's investments to make sure their maturities provide sufficient liquidity to pay future claims. Finally, they can review premium rate increases to ensure that they are sufficient to cover an insurer's expected losses.

Our survey found that 21 states have one or more actuaries on staff to work on health insurance matters, and 11 others have an actuary under contract, but none on staff. However, 14 states did not have an actuary either on staff or under contract to work on health insurance.

Some states we visited reported that new responsibilities resulting from health insurance reforms placed an increasing strain on their resources. Over half the states have implemented reforms designed to improve access to affordable health insurance for small firms and their employees. Typically, these reforms impose new restrictions on how health insurers set premium rates and medically screen applicants. In particular, these restrictions address insurance company practices that have made obtaining and keeping health insurance difficult or impossible, for some people, including those who have an expensive medical condition and change jobs, or work in a firm that changed insurance companies. Implementing these new reforms has

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[3]These numbers represent full-time-equivalent staff.

[4]The eight states were Delaware, Idaho, Louisiana, New Hampshire, Rhode Island, South Dakota, Vermont, and Wyoming.

increased state insurance department workloads in several areas, including preparing new regulations and ensuring compliance with new policy and rate provisions.

KEY HEALTH INSURANCE
REGULATORY ACTIVITIES

State insurance departments' major responsibilities include regulation of insurers to protect consumers from insurer failures, unfair policy provisions, unscrupulous insurer business practices, and, in many states, excessive premiums. Any one of these problems could be financially devastating to policyholders. States try to protect consumers through a variety of regulatory activities. Past GAO studies have raised serious questions about the effectiveness of states' efforts to monitor insurer financial solvency, and our survey of states' regulatory activities found wide variations in the practices and procedures used to approve premium rates and policies.

Monitoring Insurer Financial
Solvency is Principal Insurance
Department Responsibility

The principal responsibility of state insurance departments is to protect consumers by monitoring the solvency of insurance companies. The consequences of an insurance company failure can be catastrophic to consumers. This was demonstrated by the failure of West Virginia Blue Cross/Blue Shield in 1990, where about 50,000 policyholders were left with nearly $40 million in unpaid claims. Blue Cross/Blue Shield did not pay hospitals and other health care providers for their services, and many providers held policyholders personally liable for these claims.

The West Virginia Blue Cross failure, the failure of several large life insurance companies, and concern about the financial health of other Blue Cross/Blue Shield plans have focused attention on state insurance departments' ability to protect consumers. Each state has now established a life/health guaranty association to pay the claims of failed companies; however, we remain concerned about the ability of state insurance departments to identify and resolve troubled and failing insurance companies.

We found that the number of health insurer failures nationwide has increased since the mid-1980s. State insurance departments responding to our survey reported that in 1991, they liquidated 46 companies selling health insurance.[5] Over 70 percent of the failures occurred in four states--Illinois, Louisiana, Pennsylvania and Texas. Officials told us that the six companies liquidated in Texas in 1991 had insured over 20,000 Texans. They did not know the number of policyholders who were unable to obtain replacement health insurance due to pre-existing conditions or were unable to afford the new premiums.

To try to prevent these types of failures, state insurance departments monitor insurers' financial solvency through two primary means--analyses of an insurance company's financial data and on-site examinations of insurers. Although insurance departments rely on these activities to identify troubled and failing insurance companies, we found that these reviews have significant limitations.

Insurance departments conduct analyses of company financial data, referred to as desk reviews, by examining companies' financial statements and key financial ratios. Officials in the seven states we visited believe that because insurers' financial conditions can deteriorate rapidly, desk reviews should be

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[5]California, Colorado, Georgia, Missouri and Tennessee did not respond to this survey question.

performed at least annually. However, officials in two of the seven departments told us that they did not have sufficient resources to complete annual reviews on all health insurers in their states. In the states we visited, the amount of time spent on each desk review ranged from about 1 to 40 hours. Regardless of the time spent, an inherent limitation of desk reviews is that insurance company financial data is not verified to detect errors or misrepresentation.

NAIC assists states by attempting to identify companies whose financial condition appears vulnerable and by acting as a clearinghouse for states to share desk review software. However, it has not developed uniform standards for how desk reviews should be performed, and states continue to employ a wide variety of techniques.

State insurance regulators use on-site examinations to verify insurer-reported data and to detect weaknesses and financial problems that could cause an insurer to fail. In an on-site exam, insurance department examiners evaluate the insurers' finances by reviewing a variety of insurer accounts. We believe that these examinations are too infrequent--once every 3 to 5 years--for regulators to detect solvency problems in a timely manner. Our analysis of survey results showed that in 1991, departments performed on-site financial exams on about 20 percent of their health insurers.

NAIC developed a program to accredit individual state insurance departments that meet NAIC's minimum standard for insurer solvency regulation. As of April 1993, NAIC had accredited 19 states. Past GAO studies of this program, however, identified several problems with the accreditation program.[6] We reported that the program's standards are general and have been interpreted permissively by the accreditation review teams. We also found that the program focuses on a state's legal authority, rather than on how well the department acts on this authority. Finally, in some cases, accreditation decisions were inconsistent with problems identified by the review team. As a result, the NAIC accreditation program allows state insurance departments to become accredited without demonstrating that they are effectively regulating insurance company solvency.

To protect policyholders against losses that might otherwise occur after an insurer fails, each state has established a life/health guaranty association to provide limited continuation of coverage and pay benefits. Life/health guaranty funds are established under state law and administered and financed, at least initially, by assessments to insurance companies licensed with the state. In a separate study, we found gaps in the collective safety net for life and health policyholders. When a multistate insurer fails, policyholders in some states can find themselves totally unprotected because of the differences in the associations' rules of coverage. In addition, 30 state life/health guaranty associations currently do not cover policyholders in Blue Cross and Blue Shield plans.

Limitations in insurance department examinations, concerns about the effectiveness of NAIC's accreditation program, and the gaps in state guaranty associations' coverage raise questions about the ability of state insurance departments to detect solvency problems and adequately protect health insurance consumers.

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[6] Insurance Regulation: The Financial Regulation Standards and Accreditation Program of the National Association of Insurance Commissioners (GAO/T-GGD-92-27. April 9, 1992).

Insurance Regulation: Assessment of the National Association of Insurance Commissioners (GAO/T-GGD-91-37. May 22, 1991).

Reviewing Health Insurance Premium Rates

States face a particular challenge in balancing consumers' interests for affordable insurance with insurance companies' needs to collect sufficient premiums to pay future claims. Some states rely on the market to police premiums and concentrate their attention on solvency concerns; others regulate both solvency and premiums, attempting to strike the best balance administratively. Thus, there is no consensus among insurance regulators about how best to manage these competing demands.

We found that states' approaches to regulating health insurance premium rates differ. For example, in six states, the insurance departments require detailed rate submissions, which they review prior to approving or denying the requested rates. In six other states, the insurance departments do not routinely receive health insurance rate information from insurers for first-time rates and four of these six do not receive information on rate changes. Several other states require companies to file rate information, but do not have authority to regulate insurance premiums.[7]

In response to our survey, five state insurance departments reported that they believed that their rate regulatory authority was inadequate. For example, Texas officials explained that when a health insurance company increases its rates more than 50 percent, the department contacts the insurer to ask why such a large increase is justified and whether it could be reduced, but can do no more. On the other hand, officials in Illinois do not believe that regulating health insurance premiums is in the consumers' interest. Rather, they believe that premiums are best controlled in the competitive market.

State insurance departments that have rate authority use a variety of approaches to perform this function. For example, New York requires insurers to submit detailed rate filing information for small group and individual insurance policies. Each rate filing is reviewed by an actuary to determine whether the premium rate is justified based on expected claims by policyholders. In California, only rate increases for individual policies must be filed. Although they are to be reviewed by an actuary, the reviewer said he is only able to closely review those rate increases greater than 30 percent because his other duties prevent him from performing a more detailed review. At least one state reviews rates to determine if they are competitive, rather than whether the expected losses justify the premium.

Reviewing Health Insurance Policies

Insurance regulators review health insurance policy forms because these documents are often complex and difficult for consumers to understand. Policy forms are reviewed for compliance with state laws, which often include provisions such as readability, required coverages, prohibited exclusions and a variety of administrative requirements.

In 1991, we reported that some long term care insurance policies included provisions whose restrictions would not necessarily be foreseen by the average consumer. For example, some terms for services and facilities were modified by definitions that differed considerably and could, in effect, preclude covering the intended service. One policyholder complained that his insurer would not provide benefits unless he received care in a nursing home that maintained a daily medical record for each resident.

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[7]Insurance departments' rate authority varies depending on the type of policy and the type of insurer.

Because nursing homes in his area are not required to keep such records, it would be difficult for him to collect on his policy.

We found that all states review health policy forms and use a variety of procedures. For example, Texas uses a detailed checklist and reads each policy form line-by-line. In contrast, insurance regulators in Colorado require only that the insurer certify the form complies with all state laws and regulations. A copy of the form does not have to be submitted with the certification; however, Colorado holds the insurer responsible for checking policy forms for compliance with state law.

Investigating Consumer Complaints and Insurer Market Practices

Insurance consumers are vulnerable to unscrupulous practices by insurance companies, such as high pressure sales practices, improperly denied claims, unfair discrimination, and improper denial of coverage. To protect against these problems, insurance departments investigate consumers' complaints regarding health insurers. In addition, most states perform market conduct exams to review the marketing, underwriting, rating, and claims payment practices of health insurers.

In 1991, health insurance complaints comprised about 37 percent of the approximately 344,000 consumer complaints received by 45 insurance departments. The other 5 states could not distinguish health insurance complaints from other insurance complaints in their tracking system. Our survey found that 37 states believe that the number of health insurance complaints has increased in recent years.

The level of resources dedicated to investigating and resolving consumer complaints varies widely among states, often depending on the state's population and the number of insurers licensed to do business. As of 1991, Rhode Island and the District of Columbia did not have consumer complaint sections, while California had over 100 people available to receive and investigate consumer complaints. California's staff is multilingual and the department maintains access to a language institute so that complaints can be taken from individuals who do not speak one of the languages known by department staff.

All the states we visited use complaint information to target insurers for market conduct exams because complaints received may reflect a pattern of improper practices. Some states also use consumer complaints to target solvency reviews, because complaints of slow claims payment can be an indication of financial difficulties. Such complaints are immediately forwarded to their financial analysis units for investigation.

Our survey found that, in 1991, many states performed some market conduct exams. The number of market conduct examinations of health insurers performed by a state ranged from a high of 81 in Missouri to zero in nine states, with a median of seven examinations.

CONCLUSIONS

Although it is not clear what form health care reform may take, it may involve fundamental changes in the health insurance industry that increase competitive pressures and strain insurer finances. As the Congress analyzes various reform proposals, it needs to consider what role, if any, state insurance departments will play in enforcing new requirements that may be imposed on health insurers. A reform plan should clearly specify what state insurance departments are expected to do to carry out these responsibilities. These expectations need to consider the wide variation in state insurance departments' existing legal authorities, regulatory activities and resources, and what

actions need to be taken to ensure that the departments have the necessary tools to enforce new requirements on health insurers.

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Mr. Chairman, this concludes my prepared statement. We would be happy to answer any questions you may have.

 APPENDIX I

STATE INSURANCE DEPARTMENT BUDGETS AND PERCENTAGE EXPENDED ON HEALTH INSURANCE REGULATION

State	1991 Insurance budget (000s)	Percent devoted to health
Alabama	$ 3,475	N/A[a]
Alaska	3,064	N/A
Arizona	3,066	50
Arkansas	3,200	40
California	72,122	N/A
Colorado	4,683	50
Connecticut	6,939	22
Delaware	2,998	10
District of Columbia	2,423	8
Florida	40,674	N/A
Georgia	14,322	16
Hawaii	1,660	4
Idaho	3,552	30
Illinois	14,727	19
Indiana	4,108	33
Iowa	4,061	20
Kansas	5,531	10
Kentucky	7,107	33
Louisiana	6,368	10
Maine	3,244	40
Maryland	8,486	25
Massachusetts	4,900	11
Michigan	8,644	13
Minnesota	5,488	50
Missouri	3,530	30

State	1991 Insurance budget (000s)	Percent devoted to health
Montana	966	57
Nebraska	3,698	10
Nevada	7,600	7
New Hampshire	2,400	N/A
New Jersey	14,299	20
New Mexico	2,700	13
New York	58,699	18
North Carolina	22,542	50
North Dakota	1,411	30
Ohio	12,437	40
Oklahoma	4,218	38
Oregon	5,366	N/A
Pennsylvania	13,488	40
Rhode Island	1,932	10
South Carolina	5,406	33
South Dakota	768	15
Tennessee	3,599	15
Texas	56,760	14
Utah	2,260	27
Vermont	1,857	10
Virginia	11,800	30
Washington	8,004	28
West Virginia	1,697	35
Wisconsin	5,460	40
Wyoming	2,317	8

[a]States that were unable to estimate the percentage of their budget expended on health insurance regulation.

INSURANCE DEPARTMENT STAFFING

State	Total department staff	FTEs spent on health	Number of health actuaries	
			Department	Contract
Alabama	N/A[a]	N/A	N/A	N/A
Alaska	30	N/A	0	0
Arizona	84	N/A	1	2
Arkansas	73	N/A	1	0
California	1,038	N/A	1	0
Colorado	91	N/A	1	0
Connecticut	74	15	1	1
Delaware	46	5	0	N/A
District of Columbia	42	N/A	0	N/A
Florida	N/A	N/A	5	N/A
Georgia	N/A	36	1	2
Hawaii	33	N/A	0	0
Idaho	62	9	N/A	2
Illinois	288	34	1	0
Indiana	86	N/A	0	2
Iowa	91	N/A	0	0
Kansas	147	21	0	0
Kentucky	98	N/A	0	1
Louisiana	134	4	0	1
Maine	67	27	1	N/A
Maryland	162	N/A	1	0
Massachusetts	113	13	1	N/A
Michigan	141	18	1	1
Minnesota	100	N/A	0	0
Missouri	101	18	0	N/A

State	Total department staff	FTEs spent on health	Number of health actuaries	
			Department	Contract
Montana	21	13	1	0
Nebraska	82	10	0	0
Nevada	46	N/A	1	1
New Hampshire	45	1	0	N/A
New Jersey	490	N/A	4	0
New Mexico	64	36	2	0
New York	797	N/A	10	0
North Carolina	310	N/A	1	N/A
North Dakota	39	18	0	1
Ohio	208	N/A	0	1
Oklahoma	99	38	0	0
Oregon	92	N/A	1	0
Pennsylvania	243	80	0	0
Rhode Island	40	3	0	2
South Carolina	115	19	1	0
South Dakota	22	9	0	N/A
Tennessee	98	30	0	1
Texas	1,187	153	2	N/A
Utah	52	N/A	0	1
Vermont	31	3	0	1
Virginia	157	N/A	0	12
Washington	138	24	1	0
West Virginia	49	22	0	0
Wisconsin	116	24	0	0
Wyoming	20	3	0	0

[a]Information not available from state insurance departments.

RELATED GAO REPORTS

Insurance Regulation: Weak Oversight Allowed Executive Life to Report Inflated bond Values (GAO/GGD-93-35, December 9, 1992)

Employer-Based Health Insurance: High Costs, Wide Variation Threaten System (GAO/HRD-92-125, September 22, 1992)

Insurer Failures: Regulators Failed to Respond in Timely and Forceful Manner in Four Large Life Insurer Failures (GAO/T-GGD-92-43, September 9, 1992)

Access to Health Care: States Respond to a Growing Crisis (GAO/HRD-92-70, June 16, 1992).

Access to Health Insurance: States Efforts to Assist Small Businesses (GAO/HRD-92-90, May 14, 1992).

Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (GAO/HRD-92-69, May 7, 1992).

Insurance Regulation: The Financial Regulation Standards and Accreditation Program of the National Association of Insurance Commissioners (GAO/T-GGD-92-27, April 9, 1992)

Long-Term Care Insurance: Better Controls Needed in Sales to People With Limited Financial Resources (GAO/HRD-92-66, March 27, 1992)

Insurer Failures: Life/Health Insurer Insolvencies and Limitations of State Guaranty Funds (GAO/GGD 92-44, March 19, 1992)

Small Group Market Reforms: Assessment of Proposals to Make Health Insurance More Readily Available to Small Businesses (GAO/HRD-92-27R, March 12 1992).

Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements (GAO/HRD-92-40, March 10, 1992)

Medigap Insurance: Insurers Whose Loss Ratios Did Not Meet Federal Minimum Standards in 1988-89 (GAO/HRD-92-54, February 28, 1992)

Long-Term Care Insurance: Risks to Consumers Should Be Reduced (GAO/HRD-92-14, December 26, 1991)

Insurance Regulation: Assessment of the National Association of Insurance Commissioners (GAO/T-GGD-91-61, July 29, 1991)

Private Health Insurance: Problems Caused by a Segmented Market (GAO/HRD-91-114, July 2, 1991).

Insurance Regulation: State Handling of Financially Troubled Property/Casualty Insurers (GAO/GGD-91-92, May 21, 1991).

Employee Benefits: Effect of Bankruptcy on Retiree Health Benefits (GAO/GGD-91-115, August 30, 1991).

Medigap Insurance: Better Consumer Protection Should Result From 1990 Changes to Baucus Amendment (GAO/HRD-91-49, March 5, 1991)

Employee Benefits: Improvements Needed in Enforcing Health Insurance Continuation Requirements (GAO/HRD-91-37, December 18, 1990).

Insurance Regulation: The Insurance Regulatory Information System Needs Improvement (GAO/GGD-91-20, November 21, 1990)

Health Insurance: Cost Increases Lead to Coverage Limitations and Cost Shifting (GAO/HRD-90-68, May 22, 1990)

Chairman STARK. I notice you don't draw a lot of conclusions, but there are some comments in here, and I presume that they are accurate and that the information you received was from the State insurance regulators themselves. So that when you say on page 17 that five State insurance departments reported that they believed that their regulatory authority was inadequate, I assume that you are saying that five State insurance departments felt they were not doing a sufficient job, because the State regulations didn't give them the authority to do the job.

Ms. ARONOVITZ. That is correct. Let me just say one thing about our conclusions. Any time you do a survey and try to collect baseline information to understand what States are doing, what types of regulatory authority they have, and exactly how they are carrying out these responsibilities, you may find that there are questions about your baseline data.

We had two choices. First, we could investigate the implications of what we were hearing and see if there were any conclusions we could reach. Second, we could decide not to report the data at all, because we couldn't make clear conclusions about different States, and didn't know the economic climate in every single State.

We felt that you could learn a lot from understanding what is going on in the 50 States and the District of Columbia. Therefore, we would like to provide the subcommittee with insights we learned at the States about what they are doing and how well they feel they are able to carry out their responsibilities.

The five insurance departments who told us they did not have sufficient regulatory authority cited several examples. In some cases, they have limited regulatory authority over certain health insurance products. In some States, a commissioner might have rate authority over Blue Cross plans or individual or small group plans, but not commercial insurance. So there is a lot of variation in the regulatory framework in each of the States.

Chairman STARK. You mentioned officials in Illinois did not believe that regulating health insurance premiums is in the consumer's interest. Rather, they believe that premiums are best controlled in the competitive market. Is that an insurance regulatory official who told you that?

Ms. ARONOVITZ. Yes, it is.

Chairman STARK. Is that a State position or his or her opinion?

Ms. ARONOVITZ. I believe it was the opinion of the insurance department officials.

Chairman STARK. Their opinion.

Ms. ARONOVITZ. Yes, it was their opinion.

Chairman STARK. So what they are saying is there is no benefit to the consumer from regulating health insurance premiums?

Ms. ARONOVITZ. We have that in there, because it reflects the difference in State regulatory philosophies.

Chairman STARK. That competitive pricing will do it?

Ms. ARONOVITZ. That was the view of the Illinois officials.

Chairman STARK. They are going to love Ira Magaziner, because when he tells them that he wants to control cost by the competitive market, but yet set premiums, that is going to really turn those guys on their ear.

You also mentioned in my State that they really do believe there that rate increases must be reviewed. Is that not correct? They have to be reviewed by an actuary and they have to be filed for individual policies?

Mr. ALCOCER. For individual policies only, but not for group or small group policies, so it is a small portion.

Chairman STARK. But at least there, because we have a bit of a budget shortage, if the rate increase is less than 30 percent, they don't even review it?

Mr. ALCOCER. Yes, sir.

Chairman STARK. And I figure if you know that, the insurance companies know that, huh? Do you think that was a secret? Did you have to bust some code? [Laughter.]

So if I am setting rates in my insurance company, Green Cross of California, for example, which is now a big New York stock market with million-dollar-plus executives, I am going to set the rates and stick it to the consumers. I just increase the rates 29 percent a year, right? And I go right under the fence, don't I?

Ms. ARONOVITZ. You would——

Chairman STARK. I never get a review. Can any of you tell me what 30 percent a year compounded, how long it takes a rate to double?

Mr. ALCOCER. About 3 years.

Chairman STARK. Less than 3 years, doesn't it? So in California, you could double the rate in less than every 3 years and never get a regulatory sniff, huh?

Ms. ARONOVITZ. That's right.

Chairman STARK. That is interesting.

Now, in Colorado, you say also they have to review the form of the policy, because consumers aren't able, I gather, most regulators know, to figure out what is in the insurance form. Is that the general consensus that you found among the insurance regulators?

Ms. ARONOVITZ. In most States, the insurance department has authority to review policy forms. They commit resources to different extents. In Colorado, they have an interesting situation.

Chairman STARK. Yes, they do. I was just going to comment on that. Before I asked you about that, I wanted to see if the regulatory philosophy is that insurance forms are rather complex and, therefore, it is a regulatory responsibility to review the fine print, as we lay people would say, so that we don't get gypped.

Ms. ARONOVITZ. Right. This is demonstrated a lot, if you look at long-term care insurance, for instance.

Chairman STARK. Now, what Colorado does to fulfill that obligation is require the insurance companies to check their policies, to make sure they are not gypping the consumers. Is that a fair assessment of the Colorado policy?

Ms. ARONOVITZ. That is exactly right. The insurance company will certify that they are only selling policies in Colorado that meet State law. As part of their program the insurance department intends to go and spot-check and penalize any insurance companies who have misrepresented or certified wrongly.

Chairman STARK. That is good. Do they give you any indication as to when they might get around to that?

Mr. ALCOCER. They just instituted that program starting last July.

Chairman STARK. So they are doing it now? So they are spot-checking and——

Mr. ALCOCER. The certification process was instituted last July 1.

Chairman STARK. Any idea what the penalties are, if you cheat?

Mr. ALCOCER. Ranging up to $50,000.

Chairman STARK. Total?

Mr. ALCOCER. Total.

Chairman STARK. Is that $50,000 per day or per year?

Mr. ALCOCER. $50,000 once they catch you was the way it was described to us. So it would be $50,000 likely per policy, not sold, but for policy issued.

Chairman STARK. Policy per contract type?

Ms. ARONOVITZ. Per policy form.

Chairman STARK. Per policy form. So if you had a really good scam going, you could measure the marginal return. It is $50,000 in legal fees going in, which are probably $500,000 to beat the system. If I get caught, it's $50,000 going out and I don't even have to have a lawyer, right? It is not a felony, is it?

Mr. ALCOCER. No, it would be considered to be an unfair business practice.

Chairman STARK. I don't know if most insurance companies would know what that is. That certainly wouldn't trouble them.

There is a company in Indiana, Golden Rule, that has made an art form of gypping their customers and denying claims and jacking up after-the-fact underwriting. Did you talk to anybody in Indiana about their regulatory systems there?

Ms. ARONOVITZ. No.

Chairman STARK. We will get to them later.

When you say that only 25 percent of health spending is subject to State insurance regulation, do you mean that only about 25 percent of gross premiums for policies?

Mr. HANSEN. Mr. Chairman, that is based on national health care expenditures information developed by HIAA that was slightly modified to remove disability insurance.

Chairman STARK. Is there a model plan? Is there some kind of model regulation outlined for health insurance that is like NAIC?

Ms. ARONOVITZ. NAIC.

Chairman STARK. NAIC. Do they have a——

Ms. ARONOVITZ. There are over 200 NAIC models. About 60 relate specifically to health insurance regulation and different regulatory activities.

Chairman STARK. Are they widely used or adopted?

Ms. ARONOVITZ. It depends on which model you are talking about. Many of them are very widely used. Some of them are less so.

Chairman STARK. Do you think, as we mentioned earlier, many of these reform plans would control costs by limiting growth in insurance premiums? That isn't going to sell in Illinois, but let's assume that becomes Federal law. Do you think that the State insurance regulators are prepared to enforce premium limitation?

Ms. ARONOVITZ. I think that is the essence of our message today, and that is that States differ in their ability to do many of these activities that could be part of a health reform plan. The States that currently do not regulate rates would be hard-pressed to do so. They would have to either reallocate resources, obtain expertise and other resources to assure that they could carry on these additional responsibilities. It is important to be aware and understand from a baseline standpoint where States are right now, so that Congress can consider what, if any additional responsibilities should be assigned the States.

Chairman STARK. Just a little background before this next question. Are you aware that not so many years ago, a company called IMC stole about $30 million that belonged to the Federal Government and, in addition to that, stuck a lot of hospitals and doctors in Florida with unpaid bills? President Bush's son was involved in the company and the former head of it is living in Venezuela. At any rate, are you familiar with that HMO operation?

Ms. ARONOVITZ. No, I am not.

Chairman STARK. Have you ever heard of it?

Mr. CLUFF. No, sir.

Chairman STARK. We had another one in California called Paraselsis, with all due respect to mythology or wherever Paraselsis comes from. They got away with about $11 million before we got a hold of them. Now, I understand, they are back in business. This again was an HMO over which there is precious little control.

I might just conclude by recalling some testimony in a different committee in this room, but regarding the District of Columbia. There we questioned an insurance regulator, inquiring about the requirements to set up an HMO, planning ahead to manage competition.

Dr. McDermott and I were curious about our retirement years and thought we might as well start an HMO. We determined that the requirements to start an HMO in the District of Columbia would require people with no more credentials than Dr. McDermott and myself, he carrying the lion's share of the load, I might add. A letter of credit from BCCI in the amount of $100,000, not each, but total, and we are in business.

I mean there aren't any regulations. Any clown—I am referring to the Chair—can set up an HMO, and if you look at the results, it doesn't take long to steal a good bit of money. To my knowledge, the disappearance of these funds is yet to be classified, at least in California, as a felony. A mere misdemeanor seems to be precious little problem for running off with $11 million to $30 million of the Government's money.

Having set the stage and understanding that we may be faced with mandatory HMOs across the length and breadth of the land, and in California, as we mentioned earlier, if there is such a word as "trifurcated," the regulation of HMOs, if there are any in the State of California, is spread amongst a bunch of agencies, none of which, in my opinion, have more than six or seven employees. I am not talking about the insurance commissioner, the Department of Corporations and the health department. I just don't believe they have 20 employees among all 3 of them.

Now, what kind of problems can you foresee? What would you tell Mr. Magaziner if he came to ask you about mandatory membership and the creation of HMOs in States where they don't exist? What kind of regulatory problems would you foresee, based on the experience of California having the largest number of HMOs, and the lack of any definable regulations under which they operate?

Ms. ARONOVITZ. Although I am not personally familiar with IMC, I am very familiar with the types of improper activities in which HMOs have gotten involved.

Chairman STARK. Shady practices?

Ms. ARONOVITZ. We have done a lot of work in the area of fraud and abuse related to Medicare and HMOs, and we find that they raise particular regulatory problems.

There are two areas I could discuss. First, when you have a person or a corporation who is not only providing care, but also assuming the financial risk of providing care, you have to be very concerned about the quality of care that would then be provided. One of the things we found in the work we have done is that, although quality of care issues aren't normally under the purview of the State insurance department, quality of care problems could very often be a proxy for, or be a sign of, financial solvency problems. If a company is having financial problems, one of the temptations they would have would be to possibly curtail services.

Chairman STARK. But if they were really bad apples, that could be the corporate plan, couldn't it?

Ms. ARONOVITZ. It could. If you have different State regulatory bodies looking at quality of care issues and solvency, let's say, or other types of regulatory activities, you really have to assure that the different departments communicate with each other. If they don't communicate, it is possible that the department of health could receive quality of care complaints and not understand that the department of insurance needs to know about that, because they might be an indication of solvency problems of the company.

If we go to a HIPC-type situation or more of a capitated situation, there will be a lot of consumers who at first will not understand what is expected of them and how an HMO works.

Therefore, there might be a greater number of complaints, and the State insurance department, or the department of health, or whoever would be responsible for investigating complaints, would have to ferret through and find out which ones are just based on a lack of education and which ones are really determinants of quality of care problems that could lead to an investigation of financial problems.

Chairman STARK. Go ahead. I am sorry. We are just going to do a little number game here in a moment.

Ms. ARONOVITZ. There are things to be aware of, if you are going to regulate HMOs.

Mr. HANSEN. Mr. Chairman, if I may?

Chairman STARK. Yes, please.

Mr. HANSEN. We have just seen in Washington State an example of some of the decisions that are going to have to be faced in debating health care reform. Just 10 days ago, they enacted their own health care reform system, and our review of the new law that is put in place——

Chairman STARK. This is which State?

Mr. HANSEN. Washington State. We identified 35 new tasks and responsibilities that have been assigned to their State insurance commissioner. These include such things as certifying and licensing HIPCs and monitoring the solvency of certified health plans.

We contacted the insurance department in Washington State and found out that they had been allocated 5 new positions to take care of those 35 new responsibilities. We only offer that in the way of an example of the kinds of decisions that are going to have to be faced with the diverse kind of State health insurance regulation that we have right now.

Chairman STARK. Did you have an opportunity to observe how any HMOs operate or any of the review in your work?

Ms. ARONOVITZ. Generally, yes, but not in this particular study.

Chairman STARK. Are there reserve requirements? I was just trying to indicate the potential here for "fun in the sun."

Ms. ARONOVITZ. There are requirements for reserves for HMOs.

Mr. ALCOCER. They vary by State. In some States, the requirements are much more stringent than others, but you would have to look at it on a State-by-State basis.

Chairman STARK. Would any of you have any knowledge of how good their payment record is to the providers? Are they cash, or do they run 10, 30, 60, 90 days for their payables, do you know?

Ms. ARONOVITZ. Some of our prior work has shown concerns about the adequacy or the timeliness of payment at some HMOs that have been having problems. That is one of the areas where HMOs will start to show some slowdown. But in our current work, we did not look at the specific requirements for payment.

Chairman STARK. Well, my quick calculation of the new HMO that I am about to form would show me that I need 5,000 people. I would cheat and just pick up 2,500 Medicare contracts, and get about $400 a month. That is $1 million a month, right? You ought to be able to do that without any criticism. So for $1 million a month, I only need to figure out how I can stretch my payables out for 90 days, and I have $3 million in my pocket. You can all come down to my new research facilities, and it won't be in Jackson Hole, which is an extraditable area, but more apt to be in the Bahamas, and we will figure out what to do with that $3 million.

I don't think many States have any ways to prevent that kind of thing. I mean that is in its gross—not that it hasn't happened. IMC did that fairly well. But I am suggesting that where there is this kind of potential to control that kind of dough, and the beneficiaries would not find out about it, arguably, until they got sick. That, of course, is the other side of the game.

In any of your reviews, did any of you hear about risk adjustment?

Ms. ARONOVITZ. Yes, I believe we did.

Chairman STARK. Yes? Tell me what you know. Are there any States that are able to assess risk adjustment?

Mr. CLUFF. I am not sure exactly to what you are referring, Mr. Chairman, but I do know that the NAIC has spent a great deal of effort and time over the last 2 years trying to develop two different formulas for risk-based capital, one for life-health companies and another formula for property-casualty companies. The risk-based

capital formula for life-health companies has been introduced and companies are expected to report their risk-adjusted capital as of the end of this calendar year.

It is too early to tell whether the formula that has been developed is adequate in terms of its assessment of risks and its establishment of capital for risks, and it appears that it is more focused on asset risk than on the kinds of risks that a health insurer would be most exposed to, although it does attempt to get at that to some extent. It is early to tell what is going to happen, but I think this is a good effort. It is a necessary change, and I hope that it turns out to be well done, as well.

Chairman STARK. Did you find any instances of States that had some programs that we might look to for guidelines in how to regulate these new programs?

Ms. ARONOVITZ. Yes. As a matter of fact, Paul could describe, when he was in Texas, there were some interesting activities being performed on an early warning system. Why don't you describe that?

Chairman STARK. I would like to hear about that.

Mr. ALCOCER. Texas has developed a computer database system to take information from each of the component sections of the insurance department and bring them together centrally to see if that tells more of a story about an insurer. The system provides an early warning on insurers that should be monitored or investigated. It is something we didn't see anywhere else, although California is developing something similar.

Ms. ARONOVITZ. We found another impressive regulatory activity in California. Their consumer complaint section uses over 100 employees to take consumer complaints. They are multilingual and have access to a language institute for callers who would not speak one of the languages that the State employees know. So there are a lot of interesting and innovative activities going on, although we did not evaluate the overall performance of any department.

Chairman STARK. This idea of reviewing insurance companies and their regulation is not new to GAO, is it?

Ms. ARONOVITZ. No.

Chairman STARK. It occurs to me, as I review your appendix, that you could have annoyed some insurance regulators and companies. I am just going to mention a few here, just as a prelude to my question. These start with December of 1992 and run back to November of 1990:

Insurance regulation: weak oversight, allowed Executive Life to report inflated bond values; employer-based health insurance: high costs, wide variation threaten system; insurer failures: regulators failed to respond in timely and forceful manner in four large life insurer failures; health insurance: vulnerable payers lose billions to fraud and abuse; insurer failures: life/health insurer insolvencies and limitations of State guaranty funds; medigap insurance: insurance whose loss ratios did not meet Federal standards in 1988–89; long-term care insurance: risks to consumers should be reduced; private health insurance: problems caused by a segmented market; employee benefits: improvements needed in enforcing health insurance continuation requirements; and insurance regulation: The insurance regulatory information system needs improvement.

There are more on the list, but none of them so specifically point toward the failure of insurance regulation to do much for the consumers. Have you been challenged in any of those reports? In any of those reports I read, was anybody able to establish that the information you gathered was incorrect?

Ms. ARONOVITZ. No, although I think there were people who were not pleased with our findings.

Chairman STARK. I am not asking for your popularity rating. I am just saying——

Ms. ARONOVITZ. Not that I am aware.

Chairman STARK. In those reports I just mentioned, all of which were critical of the insurance industry and/or their regulators, you would be willing to state for the record that there were no challenges made to the accuracy of the data?

Mr. CLUFF. No.

Chairman STARK. Did anybody challenge the relation of the data to any conclusions you may have written in those reports?

Ms. ARONOVITZ. Not that I am aware.

Mr. CLUFF. Only NAIC officials in previous hearings on insurance regulation.

Chairman STARK. Well, I would just urge you to keep doing what you are doing. It sounds like we need you as long as the State regulation is in the state it is in.

Ms. ARONOVITZ. Thank you very much.

Chairman STARK. Thank you very much for your testimony.

Our next panel will consist of witnesses representing the insurance industry. Gretchen Babcock is the executive director for State services of the BC/BS Association. Greg Merrill is director of State political affairs of the Health Insurance Association of America. He will be accompanied by Chris Peterson, assistant general counsel.

I welcome the witnesses to the committee. We have your prepared testimony and I would be happy to have you summarize it for me or expand on it in any manner you are comfortable.

Ms. Babcock, would you like to lead off?

STATEMENT OF GRETCHEN BABCOCK, EXECUTIVE DIRECTOR, STATE SERVICES, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Ms. BABCOCK. Thank you, Mr. Chairman.

I am Gretchen Babcock, and I am representing the Blue Cross and Blue Shield Association.

Our association has 71 independent Blue Cross and Blue Shield plans throughout the country. Collectively, they provide health benefits to nearly 70 million people. I appreciate the opportunity to testify today on the role of State insurance regulation under Federal health care reform initiatives.

My testimony touches on three areas: First, why States are in the best position to monitor and supervise health insurers under national health care reform; second, the current status of State regulation; and, third, State regulation of Blue Cross and Blue Shield plans. These remarks summarize my written testimony which has been submitted for the record.

Blue Cross and Blue Shield Association and the independent member plans have been actively supporting health reform at the

Federal and State levels for a number of years. A key component to this reform, we feel, is strict Federal standards for the conduct of health insurers.

We believe strongly that States are in the best position to implement and enforce these Federal standards, for three reasons: one, health care is organized and delivered at the local level; two, effective regulatory mechanisms are already in place at the State level; and three, States have shown they can act quickly and effectively to implement Federal legislation.

The most important reason why health insurance regulation should remain at the State level is that the provision of health care is based on these local markets. The health care needs of the community and the environment in which insurers and providers in that community meet those needs vary significantly from one place to another.

Because State government is close to these local communities, historically, States have assumed responsibility for regulating the health care market. States have developed infrastructure and staff and expertise to discharge these responsibilities, and we believe it makes much more sense to build on the existing system than to attempt to recreate at considerable cost the necessary infrastructure at the Federal level.

In addition, States have shown they can work quickly and effectively to implement Federal guidelines and uniform laws. When Congress passed medigap reform legislation in 1990, the NAIC had just 9 months to develop model laws and regulations, including the 10 standard benefit packages that Mr. Pomeroy referred to. And only 1 year later, virtually every State had adopted the statutes and regulations required by Federal law.

Even without a Federal mandate, States have worked closely with the NAIC and moved promptly to address significant problems in the small group insurance market. Since the NAIC adopted its model small group laws in 1990 and 1991, 38 States have enacted laws based on these NAIC models.

As you know, the performance of States in regulating health insurance does vary. Some States do a better job than others in carrying out this responsibility.

There is clearly room for improvement in State performance. But for the reasons noted earlier, namely the local nature of health care delivery and the existing infrastructure that is already in place, we strongly believe that States are in a better position than the Federal Government to implement health insurance market reform.

In a number of cases, State regulatory environments tend to be more stringent for Blue Cross and Blue Shield plans than for their commercial competitors. This disparity in regulation can have adverse effects on plans. However, Federal standards for insurance market reform implemented by the States should insure that all carriers operating in a marketplace play by the same rules and are regulated in the same manner.

In conclusion, we support the enactment of Federal insurance reform standards enforced by the States as a key component in national health care reform. While many States can certainly improve their current level of performance in this area, we believe that States, working together with the NAIC, are still in the best position to assure that these reforms are properly implemented and vigorously enforced throughout the health care market.

Thank you for the opportunity to testify today.

[The prepared statement follows:]

TESTIMONY OF GRETCHEN BABCOCK
Blue Cross and Blue Shield Association

Mr. Chairman and members of the Subcommittee, I am Gretchen Babcock, Executive Director of State Services for the Blue Cross and Blue Shield Association, an association of 71 independent Blue Cross and Blue Shield Plans throughout the nation. Collectively, the Plans provide health benefits protection for nearly 70 million people. I appreciate the opportunity to testify today on the role of state insurance regulation under federal health care reform initiatives.

The Blue Cross and Blue Shield Association and the independent member Plans have been actively supporting health care reform at the federal and state levels for the past several years. A key component of reform is strict federal standards for insurance market reform, implemented and enforced by the states. In addition, we have supported ensuring universal access to coverage and making coverage more affordable by building on the strengths of the current private/public health care system.

My testimony today touches on three areas: 1) why states are in the best position to implement insurance market reform under national health care reform; 2) the current status of state regulation; and 3) state regulation of Blue Cross and Blue Shield Plans.

States Should Implement Insurance Market Reform Under National Health Care Reform

We believe strongly that states are in the best position to implement and enforce federal standards for insurance market reform for three reasons: 1) health care is organized and delivered at the local level; 2) regulatory mechanisms are already in place at the state level; and 3) states have shown they can act quickly to implement federal legislation.

The key reason is that the provision of health care is based on local markets. The health care needs of a community and the environment in which insurers and providers in that community meet those needs vary significantly from one location to another. Because states are closest to these local communities, historically they have been responsible for regulating the health care market -- e.g., through insurance regulation and provider licensing.

As a consequence of this historic state role, states have developed infrastructure, staff and expertise to regulate the health care market. In considering how best to implement federal health care reform, we believe it makes much more sense to build on this existing system than to attempt to recreate, at considerable cost, the necessary infrastructure and expertise at the federal level.

In addition, states already have shown they can work quickly to implement federal guidelines. When Congress passed Medigap reform legislation in 1990, the National Association of Insurance Commissioners (NAIC), given just 9 months to adopt model laws and regulations incorporating the federal requirements -- including development of up to 10 standard benefit packages -- completed its task on time. And one year later, as required by federal law, virtually every state was certified by the Health Care Financing Administration to be in compliance with the requirements.

Another area where states have worked closely with the NAIC and have moved quickly to address a significant problem is small group insurance market reform. In 1990 and 1991, the NAIC formally adopted model state laws in this area. Since that time, 38 states have adopted insurance market reform laws, the vast majority of which are based on the NAIC models. These laws already are being implemented in about 30 states.

Finally, federal health care reform itself will improve states' abilities to regulate insurance market reform. Under many proposals supported by both federal and state officials, federal law will define clear standards for all carriers, and the strictness of those standards will result in market consolidation. This consolidation will facilitate regulation, by allowing states to focus their regulatory resources on fewer carriers. And the very strictness of the federal standards should remove those carriers with the most problematic practices from the market entirely. In addition, federal reform should remove current legislative barriers to full state regulation. Changes to the Employee Retirement Income Security Act (ERISA) will remove a major legal loophole now hampering state regulation by allowing states to regulate both insured and self-funded plans equally.

Current Status of State Health Insurance Regulation

As you know, the performance of states in regulating health insurance varies; some states clearly do a better job than others in carrying out this responsibility. This variability is partly a function of available funding and expertise and partly a function of varying state philosophy about the role of government in regulating the private sector.

There clearly is room for improvement in state performance, but for the reasons noted earlier -- the local nature of health care delivery and existing infrastructure and expertise -- we strongly believe that states are in a better position than the federal government to implement insurance market reform. The federal government does have an appropriate role in assuring insurance market reform. But we believe that role should focus on what the federal government does best -- namely, spelling out standards in federal law, and allowing state governments to do what they to best -- implementing those standards.

State Regulation of Blue Cross and Blue Shield Plans

In many cases, state regulatory environments tend to be more stringent for Plans than for their commercial competitors. One of the best examples of this situation is whether Plans must obtain prior approval for rate changes. Although most common in the individual market, some Plans also need prior approval for their small group rates. Public hearings on proposed rate changes also are required in some states. In contrast, most competitors in these states simply can implement their proposed rate increases with only a limited, after-the-fact review.

Such disparity in regulation can have adverse effects on Plans when political pressures lead to long delays and/or rate increases that are inadequate to cover claims and administrative expenses. First, it can

place Plans at a competitive disadvantage in the market, if they finance the revenue shortfall through subsidies from other lines of business. In such cases, a Plan's subsidy to its rate-regulated business could make its non-rate-regulated business less competitive. Second, if Plans finance the revenue shortfall by drawing down reserves, it can cause potential solvency problems.

Federal standards for insurance market reform, implemented by the states, should assure that all carriers operating in a market play by the same rules and are regulated in the same manner.

Conclusion

In conclusion, we support enactment of federal insurance reform standards enforced by the states as a key component of national health care reform. While many states can improve their current level of performance in this area, we believe that they, working together with the NAIC, are in the best position to assure that such reforms are enforced throughout the health insurance market.

We look forward to working with you, the NAIC and the states to assure appropriate regulation of insurance under federal health care reform.

Thank your for the opportunity to testify today.

Chairman STARK. Thank you.
Mr. Merrill.

STATEMENT OF GREGORY MERRILL, DIRECTOR OF STATE POLITICAL AFFAIRS, HEALTH INSURANCE ASSOCIATION OF AMERICA, ACCOMPANIED BY CHRIS PETERSEN, ASSISTANT GENERAL COUNSEL

Mr. MERRILL. Mr. Chairman, thank you for giving us the opportunity to testify before you today.

I am Greg Merrill, director of State political affairs for the Health Insurance Association of America (HIAA). I am accompanied by Chris Petersen, our assistant general counsel.

HIAA represents over 250 private health insurance companies which insure over 70 percent of the commercial market. With the Chair's permission, I will summarize the highlights of my testimony.

State insurance regulation remains an effective mechanism for protecting consumers' interests. State regulation of insurance has worked, because of the departments' close proximity to the consumers they are charged to protect and their on-the-ground oversight of insurers serving those customers.

This proximity has made the departments more accessible to consumers and has allowed them to react quickly to the needs of their constituents. Problems in the insurance marketplace are quite often local. A State regulatory system is more responsive to these problems and is more likely to recognize the unique, local perspective of the problem.

Safeguarding consumers' investment of premium dollars for health insurance is by far one of the most important tasks facing State insurance departments. A strength of the State regulatory system is its ability to monitor the condition of insurers operating within its borders. In those rare instances where a commercial health insurer was facing financial difficulties, State regulators have stepped in to ensure that policyholders' claims were paid. Proximity to the problem has allowed State insurance departments to provide consumers substantial protection.

In addition, State insurance departments, in conjunction with the National Association of Insurance Commissioners, the NAIC, have been leaders and innovators in health insurance reform. The NAIC developed model acts and regulations on the subject, and a significant number of States, often with the insurance departments in the lead, have enacted comprehensive small employer insurance reforms. This action by the State regulatory bodies has resulted in important protections for consumers.

A final argument for State regulation is that the system is already in place. Since the system is working, the HIAA does not believe that it should be dismantled. Replacing State regulation with a Federal scheme would be costly in terms of dollars, disruptions to the system, and in the loss of experienced regulators.

Should the system be replaced? No. Can the system be improved? Yes. Our remarks today do not comment on the specific quality of regulation in each State. Some States do an excellent job, while others could probably do better. And all States will have to do more, if the health care system is to be reformed successfully. What

we would like to comment on today is how we believe insurance regulation will have to change in a reformed environment.

As you know, HIAA has developed a vision of comprehensive reform of America's health care system. With your permission, I would like to have it included in the record. This vision calls for a number of new functions and responsibilities to be overseen by government at both the State and Federal levels.

Chairman STARK. Without objection.

Mr. MERRILL. The basic structure of health reform and its central components must be established at the national level. A Federal role is necessary to insure a uniform level and degree of coverage provided by all health plans offering the "essential package" of benefits.

All health plans must be governed by a uniform set of rules, whether the plan is offered through a purchasing pool mechanism or is sold directly to employers and individuals. This is critical to prevent market segmentation and adverse selection, as well as to establish a truly competitive and pluralistic marketplace. Only the Federal Government can establish standards to ensure that everyone plays by the same rules.

But uniform national standards and the strong Federal role necessary to achieve them do not necessarily imply a direct Federal role in the enforcement of these standards. HIAA believes that the Federal Government should create a national framework for the regulation of the health care system. Broad policy parameters would be set at the national level by an independent Federal entity. Rules to implement those policies would be developed by a set of self-regulatory bodies addressing specific elements of the health care system.

Within this Federal framework, the States should continue to play an important role. Because the most effective enforcement of rules is at the local level, States and State-level entities should play a large role in the enforcement of the national rules and standards.

An ongoing challenge will be to define and continually refine the States' role, so as to allow adaptation to local conditions, while maintaining efficiency, equity among players, and the flow of information that an integrated State and Federal regulatory structure would require.

In conclusion, HIAA believes the Federal Government must have an expanded regulatory role in developing national health insurance standards, if we are to achieve our common goal of universal coverage in the most equitable and efficient manner. We also believe that the States, because of their expertise and proximity to local concerns, should have an important and expanded role to play in implementing and enforcing the new national standards.

This concludes my prepared remarks and we would be pleased to answer any questions, Mr. Chairman.

[The prepared statement and attachment follows:]

TESTIMONY OF GREGORY MERRILL
Health Insurance Association of America

Thank you for giving HIAA the opportunity to testify before you today. I am Greg Merrill, Director of State Political Affairs for the Health Insurance Association of America. I am accompanied by Chris Petersen, our Assistant General Counsel. HIAA represents over 250 private health insurance companies which insure over 70 percent of the commercial market.

State Insurance Regulation

State insurance regulation has been, and is, an effective mechanism for protecting consumers' interests. State regulation of insurance has worked because of the departments' close proximity to the consumers they are charged to protect. This proximity has made them more accessible to consumers and has allowed them to react quickly to the needs of their constituents. Problems in the insurance market place are quite often local. A state regulatory system is more responsive to these problems and is more likely to recognize the unique, local perspective of the problem.

Safeguarding consumers' investment of premium dollars for health insurance is by far one of the most important tasks facing state insurance departments. The strength of the state regulatory system is its ability to closely monitor the condition of insurers within its borders. In those rare instances where a commercial health insurer was facing financial difficulties state regulators have stepped in to ensure that policyholders claims were paid and that people received the medical care that was required. Proximity to the problem has allowed state insurance to provide consumers substantial protection. In the area of insurer solvency, the states' track record have been much more impressive.

In addition, state insurance departments, in conjunction with the National Association of Insurance Commissioners (NAIC), have been leaders and innovators in health insurance reform. The NAIC developed model acts and regulations on the subject and

a significant number of states, often with the insurance departments in the lead, have enacted comprehensive small employer insurance reforms. This action by the state regulatory bodies has resulted in important protections for consumers. Forty one states have enacted insurance rate regulation, thirty six states require guaranteed renewability and thirty two states have guarantee issue. The state insurance departments have also been active on other access issues such as individual reform in Ohio and Medicaid reform in Oregon.

A final argument for state regulation is that the system is already in place. Since the system is working, the HIAA does not believe the it should be dismantled. Replacing state regulation with a federal scheme would be costly in terms of dollars, disruptions to the system, and in the loss of experienced regulators.

Should the system be replaced? No. Can the system be improved? Yes. States do an excellent job, others could probably do better; all states will have to do more if the health care system is to be reformed successfully. What we would like to comment on today is how we believe insurance regulation will have to change in a reformed environment.

<u>**HIAA's Vision of State and Federal Responsibilities**</u>

As you know, HIAA has laid out a vision of comprehensive reform of America's health care system. (I have attached it to my written statement for the record.) It would provide universal coverage, and cost containment through the competitive market. This vision calls for a number of new functions and responsibilities to be overseen by government at both the state and federal levels.

Comprehensive Federal Reform

The basic structure of health reform and its central components must be established at the national level. Only the federal government can ensure universal coverage for all Americans. State-by-state reform, even at a comprehensive level, has a number of significant drawbacks. The most destructive of these is economic competition among states that would be created by the imposition of state-based employer mandates and taxes to assure universal coverage.

Another primary concern is that the coverage provided to all could differ from state to state, in terms of benefits and plan design, making "universal coverage" a relatively amorphous phrase. Lastly, state-based reform implies a lack of federal financial assistance, which would be particularly detrimental to states with disproportionate shares of financially vulnerable businesses or individuals who would require assistance to achieve universal coverage.

All Health Plans Follow the Same Rules

A strong federal role is necessary to ensure a uniform level and degree of coverage provided by all health plans offering the "essential package" of coverage. Health plans sponsored by insurers, Blue Cross/Blue Shield, HMOs, self-funded entities, government, or others must be governed by a uniform set of rules, whether the plan is offered through a purchasing pool mechanism or is sold directly to employers and individuals. This is critical to prevent market segmentation and adverse selection, as well as to establish a truly competitive and pluralistic marketplace. Differing state requirements add needless complexity, raising administrative costs without providing commensurate value to consumers. Only the federal government can establish standards to ensure that everyone plays by the same rules. States should not be allowed to enact standards that are different from those prescribed by the federal government.

Proposed Regulatory Framework

Uniform national standards and the strong federal role necessary to achieve them do not necessarily imply a direct federal role in the enforcement of these standards. HIAA believes that the federal government should create an independent federal entity, perhaps like the Securities and Exchange Commission. This independent federal entity would develop broad policy parameters and oversee the development and implementation of these guidelines by a set of self-regulatory bodies. These self-regulatory bodies would develop, implement and enforce rules of conduct for all players in the health care system. Together, these bodies would make up the federal structure that is the primary regulator of the health care system. This regulatory framework would encompass all interested parties in the health care system -- providers, insurers, employers, government, and the public.

Direct federal government responsibilities would be necessary in the following areas:

- establishing and enforcing individual and employer mandates,
- providing subsidies to financially vulnerable individuals and employers,
- revising and administering the tax code,
- encouraging managed care programs in public programs, and
- developing and implementing tort reform efforts.

The self-regulatory bodies would perform the following functions:

•establish consistent rules of market behavior for all health plans -- those provided by insurers, self-funded employers, HMOs, government, or any other entity -- including:

- guarantees that coverage would not be cancelled, terminated or not renewed because of the health status or claims experience of the individual or group,

- prohibit insurer rating practices that create large rate differentials for groups of similar age, gender and geographic composition, and

- create rules for coverage of pre-existing conditions;

•develop consistent rules for provider payment across public and private payors alike which would eliminate cost-shifting;

•define essential benefits package(s);

•establish standards for electronic data interchange;

•develop and implement anti-fraud efforts;

•establish data requirements for outcomes research and the development and implementation of practice protocols; and

•oversee or perform technology assessment.

<u>The States' New Role</u>

Within this federal framework, the states should continue to play an important role. The most effective enforcement of rules is at the local level; thus, states and state-level entities should play a large role in the enforcement of the national standards.

States could also continue to be involved in such areas as capital expenditure planning and determining the proper mix of providers. An ongoing challenge will be to define the states' role so as to allow adaptation to local conditions while maintaining efficiency, equity among players, and the relative simplicity that a federal regulatory framework offers.

The reforms proposed here do not apply to coverage outside of the essential package, such as disability income, supplemental hospital indemnity, specified disease, Medicare supplement, long-term care insurance, or the new supplemental medical insurance policies that will develop once the essential package has been defined. HIAA believes that these types of coverage should continue to be regulated and sold as health insurance products are today.

Regulation of Non-Health Insurance Products

Although HIAA endorses a strong federal role in the regulation of the health care system, including health insurance, we do not advocate that this federal role be extended to other non-health insurance products. There are a number of factors distinguishing health care/health insurance from other insurance products that result from the significant differences among the markets for health and non-health insurance products, and which make states the more appropriate regulator.

Conclusion

The federal government must have an expanded regulatory role in developing national health insurance standards if we are to achieve our common goal of universal coverage in the most equitable and efficient manner. The states, because of their expertise and proximity to local concerns, also will have an important and expanded role to play in implementing and enforcing the new federal standards.

HIAA

Health Insurance Association of America

VISION STATEMENT

Our vision is a society of healthy individuals and communities. Our nation, through systemic change, will build upon our employer-based system to create a consumer-responsive, prevention-focused, affordable and cost-effective health system which fosters individual responsibility, human dignity, improved health status, and enhanced quality of life for all.

VISION GOALS

- *Promote a healthy and productive existence for all Americans, maximizing the dignity and quality of life for each individual.*
- *Encourage Americans to take personal responsibility for maintaining good health regarding lifestyle factors within their ability to control.*
- *Recognize, as a society, that heroic efforts to extend life are not always appropriate or desirable. Dignity, quality of life, and the potential of returning to a healthy existence must be considered in treatment decisions and in the allocation of resources.*
- *Provide compassionate care to all people, especially to those who are chronically or terminally ill and cannot recover from their illnesses.*
- *Stabilize health care costs as a percentage of individual financial capacity--earned income and other sources.*
- *Harmonize health care spending with other essential national requirements--the environment, education, the economy and security.*

March 24, 1993

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GUIDING PRINCIPLES

Reform of our health care system requires comprehensive change. Change must include a shift in emphasis away from sickness and repair and toward health and wellness. The principles below comprise a unified whole, not a cafeteria menu. All elements integral to universal coverage and cost containment must be implemented together, not piece-meal nor staged over time one state at a time. HIAA believes that reform of our system must be guided by the following principles:

1. Reform must rely on competitive, pluralistic, and flexible delivery and financing systems in which all players--public and private alike--abide by the same rules. Government should not anoint winners; winners should be determined by the marketplace--a marketplace free to abandon failures and embrace promising new ideas.

2. Universal, "cradle to grave" coverage must be achieved by requiring all employers and individuals to pay for an essential package of benefits which should include primary, preventive and catastrophic coverage. Government cannot shirk its role; it must help subsidize those employers and individuals who cannot afford to purchase an essential package.

3. Insurers and other private payors must issue and renew coverage for all. To protect insurer solvency and maintain employer incentives to control costs and promote employee wellness, insurers can, within limits, establish premium rates which reflect risk. Coverage must be portable; there must be no pre-existing condition limits once in the system; and the problem of "job lock" must be eliminated.

4. Reform must build on our employment-based system. Employers' active participation in financing, selecting, and administering an essential package of coverage is critical to maintaining an open, flexible, and innovative health care system. Given their significant financial commitment, employers must retain control over their employees' health care coverage. Therefore, requiring employers to participate solely through group purchasing pools would invalidate the cornerstone of our employer-based system.

5. Changing the delivery system is fundamental. Managed care should be the primary vehicle for achieving sustained systemwide cost savings; we must allow it to evolve and develop into its next generation, including full participation of Medicare and Medicaid beneficiaries in managed care systems. A defining element of managed care systems will be their ability to collect and publish data which allow purchasers to compare outcome and price information. Employers and managed care systems will also provide incentives that promote healthy lifestyles and

personal responsibility. Managed care alone may not sufficiently control systemic health care costs. Therefore, alternative approaches (such as expenditure targets and all-payor systems) should be explored as an additional means of controlling health care costs.

6. Government's role must be one of an enabler, not of a "doer". A primary and essential function must be to eliminate cost-shifting to private payors. Self-regulatory bodies will develop, implement and enforce rules of conduct for all players. These include rules of market behavior for all private and public payors, rules for providers to follow to ensure consistent payment levels which eliminate cost-shifting, and standards for electronic data interchange and for reporting outcome and cost information. Government-sanctioned self-regulatory bodies will also define essential package(s) of care, evaluate technologies for their cost-effectiveness, and establish a mechanism for pooling certain cost and utilization data. In addition, government must enact legislation reforming the malpractice adjudication system.

7. Tax preferences should be limited to the essential package of care, thereby motivating the public to seek the best value and providing additional revenue to finance expanded health care coverage.

CREATING A WORKING HEALTH CARE SYSTEM

We Americans have shorter life spans, higher infant mortality rates, and higher rates of violent death than do the citizens of other industrialized countries. Yet we pay more for health care per capita and more in total health costs--close to $900 billion a year--than does any other country in the world. Furthermore, an estimated 37 million people in the United States do not have health care coverage; if we as a society continue "business as usual," that number is expected to reach 40 million by the year 2000.

To make matters worse, the private sector has had to shoulder more than its fair share of the costs. The Prospective Payment Assessment Commission estimates that, in 1990, private payors paid $22.5 billion more than the costs incurred by their hospital patients to make up for losses hospitals experienced from the uninsured as well as Medicaid and Medicare patients. Put another way, private payors paid an average of 128 percent of actual provider costs; this amounts to almost a 30 percent "tax" on hospital costs paid by the nation's employers.

Clearly, these trends must be reversed. Over the last year, the Vision Committee of the Board of Directors of the Health Insurance Association of America (HIAA) met to discuss health care reform. The Committee members approached their task as

Americans who happen to know about health insurance rather than as health insurance executives who happen to be Americans.

HIAA's vision is a framework for comprehensive reform. Its underlying premise is that everyone with a stake in the success of American health care, including insurers, will have to do what it takes to create a working health care system. It reflects the conviction that the nation's health care needs can best be met by a competitive and pluralistic system, not a monolithic one, and that the private sector will continue to play a dominant role in financing health care. It calls for universal coverage for all and changes in the behavior of providers, payors, including insurers, and the public. It advocates that government be an "enabler," not a "doer," that it eliminate cost-shifting, and that it establish guidelines for everyone to follow. Our vision is premised on comprehensive reform; all initiatives central to its goal of universal coverage and cost containment must be implemented together, and in coordination with one another, to ensure maximum success.

Taken together, these reforms will lead to a sustainable reduction in the growth of health care costs and improve the health of the American people. We recognize, however, that these reforms will require significant new government spending. We have identified one possible revenue source--a limit to the tax preference employer-sponsored health insurance currently enjoys--but we recognize that other sources will be needed as well. It is critical that these newly generated tax dollars be applied only to building a health care system that will produce long-term sustainable savings; new revenues should not be wasted perpetuating the status quo.

The health insurance industry anticipates further discussion on many aspects of the system it proposes. Some areas need more thought, and some gaps need to be filled. As areas of uncertainty are clarified, this paper, which is not final, will be modified to reflect these changes. Some lack of specificity will have to be tolerated while we struggle to find solutions to difficult issues. (For purposes of this discussion, "health care" refers to services to prevent, diagnose or treat medical conditions. The reforms proposed here do not apply to coverage outside of the essential package, such as disability income, supplemental hospital indemnity, specified disease, Medicare supplement or long-term care insurance.)

COMPONENTS OF THE NEW SYSTEM

1. *Based on Pluralistic Financing and Delivery Systems*

Reform must rely on market-based pluralistic and competitive financing and delivery systems. Pluralism and choice are what engender competition--competition among ideas, among companies, among plans, and among values such as cost, quality and convenience. Only true competition can assure that our health

care system remains flexible and open to innovation, so that it will continue to evolve to better meet consumers' needs in the future. A system with many buyers and sellers will assure breadth and depth of services and responsiveness to consumers. Market forces must be allowed to determine which systems shall succeed.

Comprehensive health care reform will require an expanded federal role to eliminate costly variations in state regulation and assure uniform standards--a level playing field--for all public and private payors. It will also require that government remove barriers to the growth of pluralistic, competitive systems.

2. *Builds on an Employer-Based Foundation*

Employers have a unique interest in maintaining employee health--as it affects productivity. Therefore, employers must provide coverage for all their employees and dependents. Employers will pay for at least part of this coverage. Some employers will receive government assistance to help cover their employees.

All employers, regardless of their size, will select plans based on the performance of competing managed care systems. A system built on an employer base is categorically inconsistent with the concept of exclusive group purchasing that bypasses employers altogether, thus relieving them of their responsibilities. Purchasing pools, such as group association and multiple employer plans, are common methods of obtaining coverage. We have no objection to a variety of demonstrations and experimentation with other forms of purchasing pools provided employer participation is voluntary. In no case should employers be required to buy health insurance solely through group purchasing arrangements.

A competitive and pluralistic system should allow purchasing pools to exist side by side with other methods of arranging coverage. **Insurance reform measures will prevent any one entity from bearing an inequitable share of risk because all payors will follow the same market rules to guarantee coverage.**

In addition, employers should:

- be free to experiment with and invest in a variety of approaches in providing an essential package of coverage;

- provide incentives to promote healthy behavior; and

- have incentives to help restrain costs because some element of their experience is considered.

3. *Achieves Universal Coverage for an Essential Package*

All Americans will have continuous coverage for an essential package of primary, preventive, and catastrophic care. Achieving universal coverage will require a series of mandates--on government, employers, insurers and individuals. How to divide these responsibilities will probably be the most difficult and controversial aspect of health care reform. Ultimately, it will be a political decision, not a health care decision. Clearly governments--federal and possibly state--will bear the cost of covering low-income people. Employers, in our view, should at the very least be required to incur the costs of offering health insurance to their employees.

HIAA supports a requirement that employers help pay for coverage for their employees and dependents. Even a modest employer payment would heighten employer cost consciousness and help restrain health care inflation. So-called employer mandates, however, are in effect a mandate on employees as well as employers, since employee premium contributions are envisioned in virtually all employer mandate plans. We are reserving judgment on how the costs should be shared between employer and employee, recognizing that there are practical limits on the ability of both employers and employees to shoulder the financial costs of a health care mandate. It may be necessary--however the cost is divided--to phase in the mandates over a period of years, taking account of any other employer mandates--such as increases in the minimum wage--that may be imposed at the same time. If an employer mandate is phased in, it will be necessary to coordinate it with other aspects of health care reform. For example, certain aspects of insurance market reform are not feasible absent a mandate; the two reform measures must be synchronized.

To achieve universal coverage, the following steps must be taken:

- Government must require all employers to arrange and help pay for an essential package of coverage for their employees and dependents. All individuals--those employed and those not connected to the work force--are required to obtain such coverage.

- Government must help employers and individuals who cannot afford to purchase an essential package. (Certain employers receive financial help, but they cannot "opt out" by paying a tax instead.)

- All individuals--those employed and those not connected to the work force--must receive the same tax incentives to purchase an essential package.

- The essential package covers primary, preventive, and catastrophic care. Government will authorize an independent body of providers, payors, employers and consumers to define the essential package of coverage. The design of this package must be flexible to encourage cost-conscious

behavior; it must have inherent limits to prevent continuous expansion, recognizing that people's wants and desires may exceed society's resources; and it must not overlap or duplicate medical care coverage available elsewhere such as under workers' compensation and automobile insurance.

- There should be no difference in the essential package of coverage received by the poor and the non-poor. Government will finance coverage for low income individuals, but there will no longer be the need for a separate Medicaid program.

4. *Ensures Universal Coverage Through Market Reform*

Market reform must be premised on a government requirement that all individuals and employers purchase coverage. In this environment, all health plans will be subject to national rules of market behavior to guarantee universal and continuous coverage. The same rules will apply to all health plans, whether offered by commercial insurers, Blue Cross/Blue Shield plans, HMOs, self-insured employers, government, or any other entity. Problems such as "job lock" and lack of coverage for pre-existing conditions will be resolved. The rules of market behavior will:

- require that coverage be made available to every employee in an employment-based group;
- assure that every individual will be able to purchase the essential package, regardless of their health, financial or employment status;
- guarantee that coverage will not be cancelled, terminated or not renewed based on the health status or claims experience of any individual or group;
- prohibit insurer rating practices that create large rate differentials for groups of similar age, sex and geographic composition;
- maintain, at the same time, insurers' ability to calibrate rates to risk--pure community rating results in market disruption and works against cost containment in a variety of ways; and
- establish a form of reinsurance or risk-sharing to compensate for inequitable distribution of risk.

5. *Creates Sustained Cost Containment By Systemic Change in Financing and Delivery Systems*

Changing the health care delivery system is fundamental. The actual delivery of care must be substantially better organized than it is today to meet the needs of patients, purchasers, and providers. Therefore, managed care should be the primary vehicle

for achieving sustained systemwide cost savings, and must be allowed to evolve and develop to its next generation. Managed care systems will serve the health care needs of communities by offering essential packages of care; they may also offer supplemental coverage.

Different forms of managed care coverage will compete on a level playing field. These competing forms of coverage include plans employing managed care techniques such as utilization review as well as managed care structures such as HMOs, PPOs, other network-based health plans, and evolving models. However, a defining element of all managed care systems will be their ability to collect and publish data which allow purchasers to compare outcome and price information across managed care systems.

Managed care systems will be permitted to pay providers in a variety of ways that encourage cost-effectiveness and quality care, including physician risk-sharing incentives, so that providers are rewarded for the cost-effective use of medical resources. New payment systems should encourage greater provider autonomy in decision-making and reduce the "hassle factor" that now results from micromanaging by payors.

Managed care systems will be user-friendly, efficient, and paperless. Administrative costs, and waste and fraud, will be significantly reduced. Improved alliances between providers and insurers will promote enhanced financial and managerial control of managed care systems, timely and responsive customer service, quality assurance programs, and fraud prevention.

Both managed care systems and employers will provide incentives that promote healthy behavior including discounts, promotions, and education. These incentives will reduce health care costs related to unhealthy lifestyle choices and will promote personal responsibility for one's health.

Given government's enormous buying power and its ability to influence provider costs, there should be strong incentives, perhaps requirements phased in over time, that Medicaid and Medicare beneficiaries fully participate in managed care systems to eliminate cost-shifting and control costs and utilization.

As managed care continues to develop, it will result in significant cost containment. However, managed care alone may not sufficiently control systemic health care costs. Therefore, alternative approaches (such as expenditure targets and all-payor systems) should be explored as an additional means of controlling health care costs.

6. *Controls Systemwide Costs Via New Government Role*

Government will establish an entity that oversees and relies on one or more self-regulatory bodies to develop, implement and enforce rules of conduct for all players in the health care system. The regulatory framework will include all interested parties in the health care system--providers, insurers, employers, government, and the public. One, or possibly several, self-regulatory bodies will perform the following functions:

- establish consistent rules of market behavior for all health plans--those provided by insurers, self-insured employers, HMOs, government, or any other entity (see point 4);

- define essential package(s) of coverage that is made available to all, regardless of their income, age or employment status (see point 3);

- establish rules for providers to follow which ensure that they set consistent payment levels for all public and private payors for the same service. These rules should:

    - recognize that different payors may use different payment methods; and

    - assure that payments reflect real economic costs and value to providers and payors (such as convenience, service, adherence to quality standards, cost-effective practice patterns, or meeting additional contractual obligations).

    (In no case, however, should the rules allow providers to grant discounts to one payor simply by increasing the cost to another payor. The most important outcome of these new rules is to eliminate government's chronic failure to pay the true costs of care for poor and elderly Americans. In other words, Medicaid and Medicare should no longer receive special deals with providers at the expense of the rest of the population.)

- develop standardized guidelines for electronic data processing and a nationally uniform claim form to achieve an efficient and paperless system;

- evaluate technologies (i.e., drugs, procedures, and equipment) for their cost-effectiveness; sanction clinical guidelines (developed by appropriate professions) that can be used as legal defense against malpractice claims; determine valid experimental treatments eligible for reimbursement through participation in clinical trials;

- establish standards for the reporting of outcome and cost information published by managed care systems;

- establish a mechanism for pooling certain cost and utilization data on a regional, state and/or national basis to assist all payors in controlling costs and utilization, to help managed care systems produce outcome and cost data, and to help the government-authorized entity to develop guidelines that ensure that providers set consistent payment levels;

- enact legislative reforms of the malpractice adjudication system;

- enact legislation that allows insurers to exchange information for the purpose of identifying fraudulent providers; and

- consider actions needed to change the mix and supply of physicians and to increase the supply of physicians in inner cities and rural areas.

7. *Establishes Equitable Rules for All*

Government will require all public and private payors to play by the same rules. To achieve this level playing field, the regulatory framework must:

- avoid duplicative or overlapping regulation among the states or between the state and federal levels;

- remove all state regulatory control over anti-managed care laws, mandated benefits laws, and provider contracting laws;

- prohibit states from mandating additions to the essential benefit package; and

- amend ERISA to allow this regulatory structure to successfully implement the above responsibilities.

8. *Promotes Equitable Tax Policy*

Government must implement tax policies that eliminate perverse incentives for health care spending.[1] An unlimited tax preference for employer-sponsored health benefits does not promote cost-consciousness among employees. Instead, tax preferences for the essential package of coverage should be:

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[1]As noted earlier, this vision addresses reform of the acute care medical system; it does not address long-term care financing reform. HIAA continues to support several recommendations in the latter area, including favorable tax treatment of long-term care insurance, on the grounds that the increased availability of affordable private insurance will have a significant impact on reducing future public (Medicaid) spending on long-term care.

- capped at a level equal to the essential benefit package;
- extended to the self-employed and to those who purchase the coverage outside of an employment setting;
- inapplicable to any premiums for health benefits in excess of the essential package; and
- inapplicable to cost-sharing requirements, such as deductibles and copayments, for the essential package.

Employers would continue to be allowed to deduct 100 percent of their contributions to employees' health coverage, even if their contributions are for coverage in excess of the essential package. (But employees are taxed on the excess.) In addition, the inequitable taxation of various payors must also be addressed to help level the playing field in the new system.

The revenues from these tax changes should be used only to help pay for health care reform. HIAA could not support these tax changes if cost-shifting is not adequately addressed or if the revenues generated from these changes are not specifically applied to health care reform.

SYSTEMIC FACTORS DRIVING COSTS ARE SLOWED

We have proposed many ways to create a sustained reduction in the growth of health care spending. Everyone will have continuous coverage so people will not wait until they are ill before seeking care. Managed care systems will discourage excess doctor visits, unnecessary hospital and specialist care, and technology use that is not cost-effective. Physicians will be empowered to practice effective, not defensive, medicine. Managed care systems will offer essential packages of care that will compete on price and value.

Providers will not be able to shift costs among payors, so true market competition will compel providers to become more efficient. A government-authorized entity will evaluate, and slow the use of, expensive technologies that are not cost-effective. Administrative simplicity, a paperless system, and standardized claim forms will save money and help control fraud and waste. Coverage of preventive care and incentives for healthy lifestyles will pay off over the long-run. Tax advantages will be limited to the value of the essential package of care, thereby motivating everyone to seek the best value.

Successful reform will yield measurable results and trends that will compare favorably to those of other nations on costs and on a variety of quality measures (such as mortality, percent who smoke, and height/weight standards).

HIAA will continue to refine its vision of health care reform. However, we are committed to achieving the objectives outlined.

Fixing the health care system will lift a sizable burden from our collective shoulders, yielding resources and liberating energies for other critical issues on the nation's social agenda.

SEPARATE ISSUE PAPERS

Additional issue papers are being developed on selected subjects. In some instances, these are descriptive papers discussing the pros and cons of the issue. In other cases, these are supplemental papers providing more detail than what is proposed herein. Topic areas include:

1. Problems in using premiums caps to control costs
2. Centrality of employers in providing coverage
3. Problems in using group purchasing pools as the only means of gaining coverage
4. Extent of tax-favored treatment for health insurance
5. Nature of federal and state responsibilities
6. Implementation and enforcement of employer and individual mandates
7. Insurance in the new market
8. Determining the essential package of coverage
9. Medicare and Medicaid in health care reform
10. Technology assessment
11. Tort reform
12. Individual responsibility, wellness and prevention
13. Medical care coverage under Workers' compensation and auto insurance
14. Eliminating fraud and waste
15. Long-term care
16. Electronic data interchange

Chairman STARK. I was just looking at your proposed regulatory division here. You would leave antifraud efforts up to self-regulation, is that correct?

Mr. PETERSEN. We would have antifraud efforts undertaken at the State level, not self-regulation, it would be State antifraud laws.

Chairman STARK. What would you do with multistate operators?

Mr. PETERSEN. We believe, as was stated in our opening remarks, that the State regulatory bodies are much closer to the consumers and, thus, they are more——

Chairman STARK. How does the State regulator in Iowa help somebody in Kentucky who buys something by mail or dials a 1–800 number? How close can you be?

Mr. PETERSEN. Well, the insurance department in Kentucky would enforce the protections for the Kentucky residents.

Chairman STARK. On an insurance company in Iowa, with no presence in Kentucky, how do they get jurisdiction?

Mr. PETERSEN. Under the Unfair Trade Practices Act.

Chairman STARK. Which Unfair Trade Practices Act?

Mr. PETERSEN. Kentucky's Unfair Trade Practices Act, in order to market, they would have to comply with those standards.

Chairman STARK. No, they don't. A 1–800 number or by mail? Come on. How many cases do you know of in the past 10 years where a State has gone after an out-of-State marketer by mail or over the telephone?

Mr. PETERSEN. I don't have any specific numbers.

Chairman STARK. Two? Three?

Mr. PETERSEN. I am sorry, I am not——

Chairman STARK. Do you really think that goes on in any States?

Mr. PETERSEN. We believe that the Unfair Trade Practices Standards Act and antifraud statutes——

Chairman STARK. Are sufficient?

Mr. PETERSEN. Yes.

Chairman STARK. All right. How would the HIAA suggest that we control costs? Everybody is talking about cost, whether it is bidding or whether it is setting premiums or whether it is setting costs on the providers. How do you think that should be done? What is the HIAA's position on that, Mr. Merrill?

Mr. PETERSEN. As far as premiums, we would advocate national——

Chairman STARK. No, no. What is your position on how costs should be controlled?

Mr. PETERSEN. We believe that managed care will be the ultimate answer to control costs, so that is how we would foresee the future.

Chairman STARK. I am going to press you a little further. Is that by setting premiums, controlling the rate of increase of premiums, or by controlling the charges of providers?

Mr. PETERSEN. We would support controlling the increases of premium rates. We have supported that and we would support caps on how much premium rates may be increased on an annual basis.

Chairman STARK. Now, are you aware that a large number of your members have organized into a group that are supporting cost

controls? The group is being led by the former president of your association. Are you aware of that group and its interests?

Mr. PETERSEN. Which organization are you referring to?

Chairman STARK. I am referring to a group of small insurance companies who are importuning us to use cost controls, so that they are able to compete with the five big guys that just quit your association and are out there peddling the Jackson Hole philosophy. You are unaware of that?

Mr. PETERSEN. There are competing views within the insurance industry on the best way to control costs.

Chairman STARK. You are suggesting that yours is definitely opposed to cost controls, that is your association's current position?

Mr. PETERSEN. We would like to pursue the managed care route, to see if that works.

Chairman STARK. And by saying that, you mean you are opposed to cost controls?

Mr. PETERSEN. Yes.

Chairman STARK. Would you care to outline for us what you think managed competition will be like?

Mr. PETERSEN. I am glad you have asked that question, because I think your earlier question on HIPCs to Congressman Pomeroy highlights the need for State regulation. Most national proposals include some sort of HIPC concept in them, but we don't know what HIPCs are, we don't know how they are going to operate. Will they, for instance, have one per State or one per region, several per State? Will the HIPCs compete against each other? Should they be organized on an HMO basis, PPO, indemnity carrier basis? Will there be risk adjusters? If so, what kind?

Chairman STARK. Do you know of any risk adjusters that exist in your industry?

Mr. PETERSEN. It depends on how you define a risk adjuster.

Chairman STARK. You define it.

Mr. PETERSEN. Well, a number of individual policymakers would define a reinsurance mechanism which you find in a number of States, the small group mechanism as a risk adjuster. That mechanism would allow for a nonprofit entity to spread the cost of high-cost individuals in the small employer market.

Chairman STARK. Isn't that retrospective risk adjustment?

Mr. PETERSEN. Generally, they are prospective in that you have to identify—we could be getting into semantics here, but you would have to identify the individuals to place in the reinsurance mechanism before they incurred these costs. The State of New York has a——

Chairman STARK. Would that imply medical underwriting?

Mr. PETERSEN. Yes, it would.

Chairman STARK. Let me rephrase the question. In a world without medical underwriting, do you know of any scheme for risk adjusting?

Mr. PETERSEN. I would say the State of New York's regulation 146 is probably the closest example of it. What they do is look at the age/sex mix of insurer's block of business and then shift resources to those that have, based on a ratio, a less favorable age/sex mix. They also have included in that formula sort of a conditions list, you might say, which, if there are a certain number of

conditions, that you have a greater proportion of than others, you would be compensated. So that would be the closest in a risk-free basis.

Chairman STARK. The idea of sex and age adjustments, for the most part, is about as close as anybody has gotten, and those plans don't get much closer than 20 percent. Would you say that is a fairly conservative statement of the state of the art, at least today?

Mr. PETERSEN. That probably is the state of the art, and I think what that highlights, to get back to the original question on HIPCs and why it would highlight State regulation, is that we don't know exactly what the state of the art of risk adjusters or many other functions are. So I think we believe it more appropriate for these HIPCs to be tried out at the State level and regulated at the State level, to see if they work, number one, and to see which formula is the most appropriate.

One State experimentation or one regional experimentation that does not work is much less disastrous than a national HIPC with certain set conditions with Federal regulations. Until we know if it works or not, we prefer State level.

Chairman STARK. You say in your testimony that the States should define the essential benefit package. Are you suggesting that the insurance commissioners should define the health care benefit package?

Mr. PETERSEN. The statement has the Federal body defining the essential benefit package, not the State. There is confusion and I apologize for that, but the Federal body would define it. We believe it is very important to have universal access, that everyone has the same benefits, so you would have continuity of coverage.

Chairman STARK. I misinterpreted that. That was not clear.

Cancellability guarantees, those would be State responsibilities?

Mr. PETERSEN. No.

Chairman STARK. That is again Federal?

Mr. PETERSEN. I think it is the same confusion. We believe the rules should——

Chairman STARK. Self-regulatory bodies, that would be federally defined?

Mr. PETERSEN. We liken it sort of to the SEC.

Chairman STARK. All right. I have always used the Federal Reserve, but SEC would be OK.

Mr. PETERSEN. Our next written statement will.

Chairman STARK. Would you concur that there is as wide variety in both resources committed to insurance regulation relative to the population and the size of the industry in States, as well as a wide difference in philosophy among the various States as to what is important and what isn't important? Is that a fair statement?

Mr. PETERSEN. I think that is a fair statement and reflects not only the regulatory philosophy, but also the legislative philosophy. In a particular State, when they are talking about the authority to regulate rates, quite often the legislature gives them that authority. So in those States that do not have the authority, quite often it is a legislative restriction, not a regulatory restriction.

Chairman STARK. Let's talk about managed competition, again, recognizing that neither of us is quite sure exactly what it is going to be, but it is conceivable that a large number of States, let's say

20 or 30, might not ever pass legislation to create some kind of HIPC or purchasing co-op, even if we said you must? Isn't that a fair assessment?

Mr. PETERSEN. If the Federal Government required them to do it?

Chairman STARK. Yes.

Mr. PETERSEN. I guess it would depend on what type of hammer was in the statute.

Chairman STARK. That is what troubles me. We would take over the responsibility of providing coverage and access to those people that the State chooses not to. It isn't a great leap of logic to say some States might find that financially more attractive. I am having trouble seeing how I badger Mississippi or California into both doing the same thing, when arguably there are different resources available. That is what I am getting to. What do we do?

Mr. PETERSEN. Federally, I am not certain what the solution would be. I do think your question points out—and Congressman Grandy's question pointed out—that in the rural areas of Iowa, a HIPC might not be the most appropriate response to serve their kind of needs. In theory, a rural State might determine that when we have only one or two hospitals in large regions in the State, it would be very difficult if you had negotiated rates and use HIPCs. In theory, some States might not want to take that approach. I don't know what the Federal solution would be, though.

Chairman STARK. Take the District of Columbia, where we already have testimony that the major players, the lead player, Prudential, has said it wouldn't come in and bid on the business. So much for its willingness to participate in tough areas.

What if we gave a HIPC here in the District of Columbia and nobody came? [Laughter.] Would it be reasonable for us to suggest that the Federal Government, if it is going to prescribe or going to mandate access and coverage and some kind of cost containment, ought we not to have a base plan which becomes either the safety net or the fallback position, and then allow any State that can meet those standards, either as to controlling fraud and abuse or setting premiums or assuring solvency, and then allow the States latitude to achieve those goals in their own manner, but measure them against a fairly empirical guideline? Would that be a fair basis for us to begin?

Mr. PETERSEN. Well, we believe that certain rules of the road should be established and that there should be Federal oversight, so I think we are talking conceptually the same thing, and really we are just discussing details.

Chairman STARK. I mean it has been suggested that we allow the 50 States to go ahead and each develop a plan, and then if they don't come in subsequently and do a couple of things: One, the most ludicrous suggestion was cut back on their Medicaid payments. I would be inclined to lower the speed limit on their freeways or, two, put in a trustee, God help us, in those States. Or, three, and this is after several years of a State not doing this, come in with a plan which isn't specified.

I wonder if you would find it onerous, if we just reversed that and said here is a minimum plan.

If, in fact, the States choose not to, don't want to, or in a few cases I suspect won't be able to afford it, that we are prepared to bid the plan out to Blue Cross or to a neighboring State or Canadian province, or do it ourselves, so to speak, through the National Institutes of Health or something like that. Then say any State that can go ahead and hit the mark, can go ahead and do it in their own manner.

But because we are getting much more comprehensive, I guess what I am looking for is broad standards which the State must meet, and not enforced by the Association of Insurance Commissioners, but, in effect, enforced by the Federal Government, if the various States do not do it. Does that offend your association?

Mr. MERRILL. I think that is consistent with our vision's goals and objections, and that is the national governing body would set those standards, which would include an essential benefit package, universal coverage, and then leave it up to the States within the parameters defined by that body to reach those goals. We have not talked about, as Chris said, the hammer or the enforcement mechanism.

Chairman STARK. I gather, Ms. Babcock, that the Blues don't generally belong to the HIAA.

Ms. BABCOCK. That is correct.

Chairman STARK. In view of the recent events in West Virginia, do you think that there is anything that anybody should have done prophylactically to prevent Blue Cross going broke in West Virginia?

Ms. BABCOCK. We have learned a lot of lessons from West Virginia, and I think we are in the process within our own internal organization of improving and enhancing our financial monitoring standards. So it is certainly our absolute goal to never repeat West Virginia.

Chairman STARK. Wait a minute. In reality, your salary is paid by the Blue Cross plans, right?

Ms. BABCOCK. My salary is paid by the subscribers of Blue Cross and Blue Shield.

Chairman STARK. One of which was the West Virginia one that went under, right? I don't think in any real regulatory sense that we are going to sit back with as big institutions as you all have and say that we are not going to have some regulatory authority, be it at the State or the Federal level, setting standards and reviewing, as good as the Blues are, I am sure. What I am suggesting is that the State of West Virginia insurance regulators fell down on the job. Are you going to say you fell down on the job?

Ms. BABCOCK. I think there is enough blame to go around.

Chairman STARK. How about the Federal Government, what did we not do that we might have done?

Ms. BABCOCK. I think the State of regulation at that point did not provide a role for the Federal Government.

Chairman STARK. That is generally not the procedure, but go ahead.

Ms. BABCOCK. I think we are suggesting that in this brave new world of insurance reform that we are all anticipating, that there should be a role for the Federal Government to set standards, per-

formance standards, market standards, if you will, and a number of other standards.

Chairman STARK. Let's shift to Empire, arguably a State with pretty aggressive regulation. Is there anything there that we could have done to save them?

Ms. BABCOCK. Well, I think they are doing fine at this point. They are not in a state of not being saved. They are functioning. There was a newly enacted State law that we believe will go a long way to leveling the competitive playing field in the State of New York, and that will correct a number of the competitive disadvantages that have plagued the Empire plan. I think it is a wait and see situation. I think everyone is very hopeful that plan will continue to serve its subscribers.

Chairman STARK. So you think that New York State is going to take care of that and that it does not need any help?

Ms. BABCOCK. We are certainly hopeful that is the case.

Chairman STARK. How about Maryland? Do you think that there is any role that the Federal Government should play in that? It seems there is some disagreement in the State as to whether there is cronyism or high lifestyles that might have led to some problems. Is there anything that the Federal Government might have done there to encourage the State insurance department of the State of Maryland?

Ms. BABCOCK. I think the Federal Government again provided the wakeup call that has caused the State of Maryland Legislature to look hard at the authority they had given their commissioner, found it lacking, increased it dramatically, again with the full concurrence and support of the plan. So I think their financial picture is looking up, they have new management and I am hopeful in that situation, as well.

Chairman STARK. Do you think that Blue Cross plans should be in the nature of public service groups or they should be first-line competitive profitmaking operations? Which do you think is generally the best description that you would apply to the Blue Cross plans?

Ms. BABCOCK. Well, they do vary. The 71 plans are all over the spectrum.

Chairman STARK. That's the truth.

Ms. BABCOCK. Again, that is a reflection of the philosophies of the individual States in which they are chartered.

Chairman STARK. Are you indifferent?

Ms. BABCOCK. To me personally, yes.

Chairman STARK. I mean to the association. If you have one Blue Cross plan that wants to go ahead with Prudential and pay executives outrageous salaries and cut payments to providers and cut benefits to beneficiaries, you are proud to have them in your organization, is that right?

Ms. BABCOCK. Well, I think you honed in on exactly the issue, which is the need to be competitive. Our plans do compete head-to-head with commercial companies and——

Chairman STARK. Well, are you proud of competing by cost shifting, causing problems for disproportionate share hospitals, by cutting back on benefits to beneficiaries, by paying $1.3 million salaries and outrageous stock bonuses to companies that are supposed

to be nonprofit? Is that the kind of thing that Blue Cross stands for?

Ms. BABCOCK. I think Blue Cross stands for trying to serve its subscribers as best we can in the markets in the situations that we find ourselves in.

Chairman STARK. Right after they take care of the chief executive officers, is that right? How do you countenance $600,000 or $700,000 salaries, corporate jets, companies that are going broke, $1.3 million just after a Blue Cross plan goes public, rips off all of the good business from the nonprofit side, puts it into a corporation that is there only to benefit the officers and directors who become shareholders with millions of dollars worth of stock, when it had built this business based on tax exemptions previously. Is that the kind of conduct that you would encourage among all your plans?

Ms. BABCOCK. Mr. Chairman, I won't try and deny that there haven't been various situations that we find embarrassing, and I think——

Ms. BABCOCK. But you live in the State.

I think the public scrutiny that some of these situations are getting has certainly prompted us to look at our ethical standards, the standards that we impose. There is going to be more accountability for all kinds of management activities.

Chairman STARK. There is enough embarrassment to go around. How would you like to be in the same political party as the regulator who is thinking of running for higher political office who turns a blind eye on those kinds of shenanigans, as well as the Governor of the opposite party who doesn't pay any attention to it? That doesn't put a politician from the same jurisdiction in a very comfortable position.

And it leads one to believe that it might be less embarrassing and more beneficial to the consumers, if there were some strict Federal guidelines in that arena. Does it make some sense? I am not on the hook and you are not on the hook and the HIAA is not on the hook. Under some circumstances, can't you see where it might be beneficial for everybody to have some broad Federal guidelines that everybody could adhere to?

Ms. BABCOCK. I think the time has come to certainly look at whether those broad guidelines and those accountability standards should be put in place. Again, whether they should be put in place by the Federal Government or by the State government, I can't say, but certainly we should all be looking at them.

Chairman STARK. Let's try it this way. Mr. Pomeroy alluded to it in testimony he made before this committee some years ago, and I am not sure he has lived to regret it. But at some point, if the States don't, for whatever reason, there are some political tensions in the State and they can't do it, or they won't do it or they can't afford it, that with the mobility of people, with regions like the one we are in right now, where we are all very close, we have three jurisdictions in everybody's backyard, that there might be some assistance and direction that the Federal Government could give allowing latitude for the States to be creative and see that these regulations are applied in the most efficient manner.

Could I imply from your previous response that maybe it is time to knock down this kind of iron-clad separation, in that the Federal

government will have no role in the regulation of insurance. Yet we are willing to negotiate that, then ought we not to be talking about where we can best work together to provide broad standards?

Ms. BABCOCK. Absolutely. There could be Federal standards and there are a lot of models for State enforcement with default Federal options, if the States can't or won't act. There are many models out there to accomplish those goals.

Chairman STARK. What I really see—and I don't know where Blue Cross is on managed competition—it seems to me you guys are out of business. If you have a HIPC, why do you need Blue Cross?

Ms. BABCOCK. Well, we definitely don't agree. We think that HIPCs will do business with Blue Cross managed care entities. We are moving more and more into the managed care field.

Chairman STARK. To the extent that Blue Cross operates an HMO or a managed care facility, yes, but we can say so long small group and individual policies.

Ms. BABCOCK. That is where we are moving, out of the indemnity business and into the managed care business.

Chairman STARK. Mr. Merrill, how about your group? What happens to the 1,200 insurers who rely mostly on the indemnity business. Where do they end up in this thicket?

Mr. PETERSEN. Well, we do not support a mandatory HIPC scheme. What we would support is a voluntary HIPCs scheme and——

Chairman STARK. You know, you just found a hornless unicorn. These guys are talking mandatory, not mandatory on the small businessman, but mandatory on your members. Don't think for a minute that is not what is lurking in the dark hearts of the Jackson Hole honchos.

Mr. PETERSEN. We are aware of that, but we are heartened by the fact that, at the State level where this issue has been discussed, it has not been a mandatory situation.

Chairman STARK. I want to give you a big wakeup call. I think that being in the supplemental insurance business is a nice business, but a lot of your members don't think that is enough. It is not exactly on today's topic, but, boy, oh boy, I think we are all dreaming. This is like saying the guy just wants to stay in the paperhanging business, he is not really interested in politics. [Laughter.]

These clowns want the whole 9 yards, Medicare and Medicaid included. That may be the best answer, and I don't mean to prejudice it. That is not what they are saying, but that is what is coming out in all the leaks that we are seeing. To be forewarned is to be forearmed.

I thank you, because I am suggesting we all may be more allied in this endeavor than we anticipate today and that Federal regulation may look a hell of a lot better to some of you in the next month or two than it does right now. If that is the case, we look forward to working with you, as this new scenario unfolds and we begin to define the unicorn, we look forward to working with you.

Thank you very much for your participation.

Mr. PETERSEN. Thank you very much.

Mr. MERRILL. Thank you, Mr. Chairman.

Chairman STARK. Our final witnesses comprise a panel of consumer representatives. They are Maryann O'Sullivan, executive director of Health Access Foundation, San Francisco, Calif.; Mr. Larry Kirsch, president, Consumer Health Advocates, Boston; and Mr. J. Robert Hunter, president, National Insurance Consumer Organization, Alexandria, Va.

As with the previous panels, all of your prepared testimony will appear in the record in its entirety. I would ask each one of you, before you proceed to expand on your own testimony or paraphrase it for me, if you have an opinion you would like to share with the Chair on the adequacy of the GAO study. You might preface your remarks with any comments you would care to make about it.

Ms. O'Sullivan, would you like to lead off?

STATEMENT OF MARYANN O'SULLIVAN, EXECUTIVE DIRECTOR, HEALTH ACCESS FOUNDATION, SAN FRANCISCO, CALIF.

Ms. O'SULLIVAN. Thank you.

I haven't had a chance, except sitting here, to review the testimony from the GAO, but it sounds to me like good useful information. You at the Federal level are going to have a lot of tough decisions to make about implementation and enforcement, and I think it gives you a sense of what you have got out there to rely on or what is not out there to rely on, probably more accurately.

I am Maryann O'Sullivan. I am the executive director of Health Access. Health Access is a consumer coalition of about 200 organizations in California. The coalition grew from a group of organizations that came together over 8 years ago, first in Alameda County in California, to address the issue of emergency patient dumping.

Health Access has long believed that the best health care system for this country is a single-payer system——

Chairman STARK. That didn't go on in Alameda County, did it?

Ms. O'SULLIVAN. Pardon?

Chairman STARK. Dumping in Alameda County?

Ms. O'SULLIVAN. Oh, you remember.

Chairman STARK. Where?

Ms. O'SULLIVAN. To Highland from everywhere.

Chairman STARK. To Highland, yes. I thought it was just because it was such a neat hospital.

Ms. O'SULLIVAN. Brookside was one of the biggest offenders, but everybody just about was involved.

Chairman STARK. I am kidding you, but go ahead.

Ms. O'SULLIVAN. Health Access has long believed that single-payer is the right way to go. However, there are six principles that we support and look for in any health care system and any reform proposals. We are actually hopeful that the Clinton plan will be a plan that we will be able to support. Hope springs eternal.

One thing that many single-payer plans and the task force plan have in common is their continued reliance on some form of private health plans. Because our health care system has developed so haphazardly, any new system should require a great deal of new attention on the front end to health plan issues related to quality and access, as well as a great deal of vigilance as these new systems develop.

While many consumers in California have been stunned by their treatment at the hands of insurers, what often leaves them even more incredulous, though, is learning that often the law doesn't protect them from insurance companies.

Laws in California's Insurance Code, including the newly enacted small group reform statute, have provisions with loopholes big enough to destroy entire insured families. We are asking Congress to take advantage of the momentum for national health reform to legislate tough Federal standards for health plans. State legislatures have too long been captive of the insurance industry, and while many implementation issues are appropriate at the local level, if tough parameters are not put in place nationally, but, rather, are left to passage by the States, we fear consumers will have few assurances of access and quality.

A combination of factors must be in place, if we are to hope for an effective new health care system. A few of those include good laws, strong leadership, well-functioning agencies and consumer friendly structures.

As the Chair mentioned earlier, California has a unique regulatory structure, whereby commercial insurers come into the jurisdiction of the department of insurance, while the State's department of corporations licenses and oversees California HMOs. Neither agency has been able to do an effective job on behalf of consumers in California.

While the department of insurance suffers from weak statutory authority, but enjoys pro-consumer leadership at the moment, the department of corporations, on the other hand, although shored up by strong legislation, suffers from an inadequate volume of staffing devoted to health matters.

Now, while HMOs underwriting standards are generally not as risk aversive as those of fee for service insurers, these health plans do require close scrutiny in terms of quality of patient care. HMOs, with their strong incentives for underservice and their sometimes suspect provider plan risk arrangements warrant very close regulatory oversight.

A split jurisdiction that I am describing in California makes little sense, though, from the point of view of consumers who are often confused about where they can turn for help.

Health Access is recommending a system of Federal minimum standards. Health care providers, institutions and expectations vary greatly from community to community, and local flexibility within a national system is critical. However, we believe that the California experience of horrific insurance industry practices, laws that give only the impression of reform, the powerful presence of the insurance industry, coupled with the relatively weak presence of consumer advocates in the State Legislature all make the case for tough federally imposed standards to control health care practices.

These standards should set floors that are minimum levels below which no State may fall, allowing States to do more for consumers if they wish. Floors set by the Federal Government need to be high enough and Federal oversight diligent enough to afford maximum consumer protections and quality assurances. States cannot be counted on to do this legislatively.

There are a number of things, of course, that are really ripe for these sort of Federal standards. There is one that I want to mention here, and that is standards that really assure widespread active participation of informed consumers in the State processes. There will be a variety of complex tasks involved in assuring that, under a new national health plan, our dollars are going to deliver the best care possible and the best quality.

Much thought needs to be devoted to which regulatory agencies should take which responsibilities. It is clear that the overarching oversight should be with the consumer dominated well-trained and appropriately financed entity which is free of financial self-interest. Simple lack of financial self-interest, though, should not be sufficient to qualify an individual to serve as a consumer representative on these entities.

Rather, most of those representing consumers need to have a highly sophisticated understanding of the dynamics of health care financing and delivery, and sufficient staffing resources to provide truly competent oversight. Some technical assistance to States should be directed to training and supporting consumer representation.

In conclusion, national health care reforms are most likely to succeed in bringing about the access and quality consumers deserve, if the Federal Government sets out clear standards regulating health insurance entities. While State flexibility is essential, tough Federal parameters complemented by consumer-dominated regulatory enforcement and visible and accountable leadership in the States is a promising formula.

[The prepared statement and attachments follows:]

TESTIMONY OF MARYANN O'SULLIVAN
HEALTH ACCESS FOUNDATION

I. INTRODUCTION

I am Maryann O'Sullivan, Executive Director of Health Access. Health Access is a consumer coalition of over 200 organizations working toward universal access to quality health benefits. The coalition grew from a group of organizations that came together over four years ago, around the issue of patient dumping. Mr. Chairman, thank you for the opportunity to testify before the Health Subcommittee of the House Ways and Means Committee regarding state regulation of insurance in the context of national health care reform.

Health Access has long believed the best health care system for this country is a single payer system. However, there are six principles we are committed to achieving and we will support any proposal which comports with those principles which are: universal coverage; comprehensive benefits; progressive financing; economic efficiency; publicly guided allocation of health resources; and accountability to consumers.

In addition to our Principles, there are four somewhat more specific Health Access Essential Elements of Health Care Reform that we have asked the California Congressional Delegation and the White House to use in measuring national health reform proposals. (See attachment B.) The California legislature in May this year passed Senate Joint Resolution 3 (SJR 3), authored by Senator Nicholas Petris and sponsored by Health Access, asking out national leaders to heed these Elements.

One thing that many single payer plans and the Task Force's plan, as it has been described, have in common, is their continued reliance on forms of health insurance to play key roles in a new national health system. You have asked me here today to comment on state regulation of insurers. Because our health care system has developed so haphazardly, any new system will require a great deal of new attention to health insurance issues related to quality and access, as well as a great deal of vigilance as new systems develop.

While many California consumers are stunned by their treatment at the hands of insurers, what often leaves them even more incredulous is learning that, often, the law does not protect them from offenses by insurance companies. Laws in the California Health Insurance Code, including newly enacted small group reform provisions, have provisions with loopholes big enough to destroy entire insured families. We are asking Congress to take advantage of the momentum for national health reform to legislate tough federal standards for health plans. State legislatures have too long been captive of the insurance industry and, while many implementation issues are appropriate at the local level, if tough parameters are not put in place nationally, but rather are left for passage by the states, we fear consumers will have few assurances of access and quality.

II. PERVASIVE AND SHOCKING INSURANCE ABUSES ARE LEGAL UNDER CALIFORNIA'S INSURANCE CODE

In November of 1989, Health Access along with Consumers Union and Parents of Kids with Cancer petitioned the California Department of Insurance (DOI) to take immediate action to protect victims of catastrophic illness, and their families, from further abuses by health insurers. In conjunction with the Petition's calls for change, the California State Assembly Insurance Committee held a day long hearing to provide Health Access the opportunity to bring forth witnesses who were preyed upon by insurance companies. Since that time, Health Access has been engaged in a campaign we call, "I Thought I was Covered," designed to bring to the public's attention the myriad of problems people with health insurance are having in securing the care they need. The sorts of complaints we have heard from individual consumers include the following:

- Discrimination Based on Preexisting Conditions: Some health insurers unreasonably discriminate against people with preexisting conditions.

- Discrimination Based on Occupation: Some health insurers unreasonably discriminate against people because of their occupation.

- Denial of Benefits for Covered Medical Procedures: Insurers have denied claims outright for covered procedures.

- Late Payment or Refusal to Pay Claims: Properly filed claims are frequently paid several months to several years late. There are also times when insurers will simply refuse to pay claims. Individuals and families are left personably liable for these bills.

- Unreasonable Escalation of Premiums: Individuals, families and employers have faced sudden dramatic premium increases, forcing many to drop coverage and leading some employers to drop employees from the employers coverage pool.

- Imposition and Nondisclosure of Caps: Health insurers suddenly impose dollar caps on coverage which are either not disclosed or not adequately explained to consumers when the policy is purchased.

- Divide and Dump Practices: Practice whereby insurers segregate the sickest insured and then raise their rates substantially, or outright cancel their policies.

II. FAILURE OF THE CALIFORNIA LEGISLATURE TO BE TOUGH ON INSURERS

Many in the California legislature are captive of the insurance industry and of others interests with vast financial stakes in the health care industry. For example, in the 1991-1992 election cycle, California insurers ranked high in the top ten contributing PACs to candidates

for the California legislature. Consumer advocates are spread far too thin and the overwhelming number of bills moving through the legislature at any given moment often forces them to watch from afar while those with a financial stake dominate the process. Two years ago, in California, in the face of state and national media attention to the kinds of insurance abuse problems described above, rival insurance interests introduced competing small group reform bills. However, the insurance industry had a great deal of difficulty coming to agreement amongst themselves about what was an acceptable reform. Finally, in 1992, California's Governor Wilson signed a modest small group reform proposal, AB 1672 (Margolin). The proposal would have no impact on the number of uninsured in the state and, absent its voluntary purchasing pool, no impact on rising health care costs. As we speak, a variety of special interest groups are descending upon California's capitol in an aggressive attempt to gut this minor reform which was due to begin to go into effect in July of this year.

In California, we expect our problems to be further exacerbated in the years to come. In 1990, the California electorate passed an initiative which imposes term limits on state legislators and reduced funding for legislative staff by one third. Term limits should fully take effect at about the time that national health care is being implemented in California. Uninformed, new legislators with insufficient staff may be even more captive of financially self-interested lobbies than the legislature is today.

III. BIFURCATED REGULATORY SYSTEM IN CALIFORNIA

California has a unique regulatory structure whereby commercial health insurance plans are regulated by the DOI (estimated by DOI personnel to be about 15-20 percent of the market) while the State's Department of Corporations (DOC) licenses and oversees all California HMOs. (It is estimated that 80 percent of insured Californians are in some form of "managed care," that is, PPOs or HMOs and the vast number of these are governed by the DOC.) While the DOI suffers from weak statutory authority but enjoys pro-consumer leadership at the moment, the DOC, although shored up by good legislation that came out of the response to the prepaid health plan scandals of the 1970s, suffers from inadequate staffing devoted to health matters. This split jurisdiction makes little sense from the point of view of consumers who are often confused about where they can turn for help.

While this split jurisdiction serves to confound consumers, by contrast, it can play very nicely into the hands of insurers allowing them to choose the regulator they prefer from time to time. For example, when Blue Cross wanted to avoid paying into a newly established state run guarantee fund, they supported legislation to allow their removal from the DOI's jurisdiction to the jurisdiction of the DOC. But, later when Blue Cross went through corporate reorganization and created new products that could not meet the DOC's tougher standards, they shifted those products over to DOI's jurisdiction.

The behavior of the DOC during recent HMO "conversions" from for-profit to non-profit entities, provide strong evidence that the DOC cannot be counted on to act in the best interests of consumers. In several instances in recent years the DOC has grossly undervalued

the worth of HMOs applying for for-profit status allowing dollars to flow to the management of the institutions rather than to investments in the public interest. This negligence, at best, on the part of DOC has resulted in the looting of hundreds of millions of dollars that could have been used for the public benefit to provide needed health care services for Californians had the HMOs been fairly valued by DOC.[1]

While HMOs' underwriting standards are generally not as risk aversive as those of other insurers, these health plans do require strict scrutiny in terms of quality of patient care. HMOs, with their strong incentives for under service and their sometimes suspect provider/plan risk arrangements, warrant very close regulatory vigilance.

IV. LEADERSHIP IS NOT ENOUGH WITHOUT STATUTORY AUTHORITY

The quality of leadership at state regulatory agencies can make some difference to the plight of consumers. In 1988 the California electorate passed a property/casualty insurance reform initiative, in spite of unprecedented massive spending against the initiative by the insurance industry. The initiative included a provision for an elected Insurance Commissioner. John Garamendi ran and won on a pro-consumer, no-campaign-contributions-from-insurers platform. His positive leadership at the DOI included strengthening the consumer complaint division and calling for a major overhaul of the health care system. According to DOI personnel, 7,600 consumer complaints have been filed with the DOI and $1,048,000 have been recovered for the complainants. However, these actions do not go far enough. A well meaning elected official is no substitute for adequate legislative protections.

V. RECOMMENDATION: SUBSTITUTE PUBLICLY RUN FEE-FOR-SERVICE INSURANCE FOR PRIVATE COVERAGE

Fee-for-service private health insurance, with its addiction to risk avoidance, has been the last and most resistant entity, dragging behind HMOs and government payers, in cost containment innovation. Medicare, for example, does a better job at controlling the per-capita

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[1]The Department of Corporations must approve the conversions including the price and the dedication of the assets to a public use. Without this approval the self-dealing transaction would not be permitted under Corporations code Section 5233. Unfortunately, the Department of Corporations has no regulations to assure that conversions proceed in a uniform manner with the appropriate public scrutiny to assure that the public's rights are protected through a fair and open procedure. The following are three examples of conversions where the public interest was not served:

- Inland Health Plan of San Bernadino (Partners Health Plan of Southern California) converted to a for-profit plan in 1985. Its fair market value for conversion purposes was estimated to be $562,000. A year later it was sold to a joint venture led by Aetna Life & Casualty Co. for $37.5 million. (LA Times, July 3, 1991, p. A3.)
- Family Health Plan went for-profit at a price of $38.5 million although Maxicare offered $50 million. FHP is now valued at 4820 million based on the price of its shares traded on the NASDQ exchange. (July 1, 1991, American Lawyer Media, L.P., The Recorder, p.1.)
- HEALS converted to for-profit status in 1987 with a $2.1 million donation to charity. In December, it was bought for $7.5 million by Qual-Med Inc. an HMO operator based in Colorado, which also assumed $17 million of HEALS' debt. (LA Times, July 23, 1991, p. A9.)

rate of cost increases than does private fee-for-service insurance. While consumer choice is an important ingredient in a national health plan, there should be no future for private fee-for-service insurance as we have known it until now. Particularly in urban areas where sufficient capacity exists, and in states like California where HMOs abound, pre-paid health plans should be made to compete, based on quality, amongst themselves and with a publicly run fee-for-service plan, all functioning within a pre-set, global budget. This Medicare-like option for all can be expected to encourage creative tensions, finally forcing fiscal accountability upon a fee-for-service system and requiring HMOs to demonstrate their relative efficiency while maintaining quality services for consumers. Each of these systems would be required to meet tough access and quality standards.

VI. RECOMMENDATION: A SYSTEM OF FEDERAL MINIMUM STANDARDS

Health care providers, institutions, practices and expectations vary greatly from community to community; local flexibility within a national health system is important. However, we believe that the California experience: horrific insurance industry practices, laws that give only the impression of reform, and the relatively weak role of consumers in the state legislative process all make the case for tough, Federally imposed standards to control heath plan practices.

These Federal standards should set "floors", that is, minimum levels below which no state may fall, allowing states to do more for consumers if they wish. However, the creation of Federal "ceilings" should be avoided. By "ceilings" we mean Federal standards which the states are prohibited from changing, even when the change would provide a new protection for consumers. An illustration of where Federal ceilings created obstacles to good reforms in California were the popular Medi-Gap reforms under which the Congress created a consumer-friendly standardized benefit package. Unfortunately, when California advocates tried to add two important benefits to the package (mammograms and pap smears) HCFA ruled California would be deemed non-compliant if they added the benefits.

Floors set by the Federal government need to be high enough and Federal oversight diligent enough to afford maximum consumer protections and quality assurances. States cannot be counted on to do this legislatively. The following is a partial list of areas where Federal standards should set parameters for state legislatures and regulatory agencies:

A. Data Collection, Analysis and Distribution

Little attention has been directed to data collection and analysis for use by consumers, other payers and regulators. Information about quality and access, provided to consumers at the point of entry into the system, to regulators and to payers will enhance informed decision making. Reporting requirements based on uniform definitions will produce useful comparative information that will empower consumers, finally, to begin to measure and compare quality of care. Areas to be measured should include health plan information about patient outcomes, numbers of complaints, length of waits, availability of specialized care, and availability of

culturally competent and bilingual providers. Easy-to-understand health plan "report cards" will create a basis for informed comparisons.

B. Needs of Low-Income Populations and Those with Special Medical and Social Needs

Provisions should be made to assure that access and quality are assured for low-income people. Low-income people should have access to mainstream plans and appropriate and provisions should be made to attract adequate numbers of provides to currently under-served areas. Also, provisions should be made to assure that those with chronic illnesses have appropriate access to specialty care and that linguistically and culturally competent care is available.

C. Integrity of Health Plan Marketing

Health Plan marketing today, by and large, relies on advertizing to encourage name recognition and the association of plans with "warm" concepts like healthy living. Marketing should be required to include relevant, standardized information to encourage intelligent comparisons. Standardized "report card" scores could be required to be part of any ad.

D. True Community Rating

Provisions should stop all risk avoidance practices by the industry and should require pure community rating, ending segregation of risk and bringing everyone "into the same room." Preference should be given to simpler, easier to monitor and enforce requirements.

E. Pooling

In today's market bargaining power between payers and plans can be grossly uneven leaving payers at the mercy of large health plans. Provisions should maximize the size of pools to enhance bargaining power and maximize coherent negotiation strategies on the part of payers and to reduce wasted administrative costs.

F. Financing

Provisions should be passed to govern financing matters such as the following: protection of consumers from insolvencies; rate negotiations and/or rate setting; the establishment of risk- adjusted rates; and health plan/provider risk arrangements.

G. Widespread, Active Participation of Informed Consumers

There will be a variety of complex tasks involved in assuring that, under a new national health plan, our dollars are going to deliver the best quality care possible. While much thought needs to be devoted to which regulatory agencies should be responsible for which tasks, it is clear that over-arching oversight should be with a consumer dominated, well trained and

adequately funded entity which is free of financial self interest. Technical assistance to states should be directed to training and supporting consumer representatives. Simple lack of financial self-interest, though, should not be sufficient to qualify an individual to serve as a consumer representative on this entity. Rather, most of those representing consumers need to have a highly sophisticated understanding of the dynamics of health care financing and delivery, and sufficient staffing resources to provide truly competent oversight.

VII. CONCLUSION

National health care reforms are most likely to succeed in bringing consumers the access and quality they deserve if the Federal government sets out clear standards for regulating health insuring entities. While state flexibility is essential, tough Federal parameters, complemented by consumer-dominated regulatory enforcement in the states, is a promising formula.

ATTACHMENT A

HEALTH ACCESS FOUNDATION

A Coalition Dedicated to Affordable Health Care for All Californians

1535 Mission Street
San Francisco, CA 94103
Phone 415 431-3430
Fax 415 431-1048

HEALTH ACCESS PRINCIPLES

Principle One: Universal Coverage

Reform should aim toward universal rather than segmented coverage, where all consumers share in a common package of health benefits and an integrated system of health care.

Principle Two: Comprehensive Benefits

Reform should seek to provide coverage that is comprehensive, including the full range of preventive, institutionalized, out-patient and long term care services needed by patients.

Principle Three: Progressive Financing

Reform should spread the burden and risk of financing health care coverage broadly based on the ability to pay.

Principle Four: Economic Efficiency

Reform should incorporate proven mechanisms for containing health care costs that do not create barriers to care.

Principle Five: Publicly Guided Allocation of Health Resources

Reform must assure that the limited resources available for health care are allocated in a manner that is equitable, medically appropriate and not left to laissez-faire forces.

Principle Six: Accountability to Consumers

Reform should ensure that the health care system is responsive and accountable to the needs of health consumers.

SOUTHERN CALIFORNIA OFFICE: 1010 South Flower Street, 5th Floor, Los Angeles, CA 90015 Phone 213 744-1656 Fax 213 748-2432

ATTACHMENT B p. 1

HEALTH ACCESS FOUNDATION

A Coalition Dedicated to Affordable Health Care for All Californians

1535 Mission Street
San Francisco, CA 94103
Phone 415 431-3430
Fax 415 431-1048

December, 1992

ELEMENTS OF HEALTH CARE REFORM
Essential to Proposals for National Reform

Proposals should assure:

- universal and equitable access
- comprehensive benefits
- quality care and choice of provider
- affordability for every individual and family

Efforts to achieve these results need not and should not require trading off any of these goals.

UNIVERSAL AND EQUITABLE ACCESS

As a right of residency, every individual should be eligible for and able to obtain quality comprehensive benefits regardless of an individual's employment status.

- Every resident should be eligible for all medically necessary care.
- Financing for every resident should be identified at the time a proposal is passed.
- All residents should be phased into the plan by the end of President Clinton's first term.
- Insurers should be prohibited from discriminating based on health history, age or any other criteria.

COMPREHENSIVE BENEFITS

- Emphasis must be placed on primary and preventive care.
- All medically necessary health care including prescription drugs should be covered.
- There should be no pre-set limits on an individual's benefits such as annual or lifetime financial caps or limits on hospital days or provider visits.

SOUTHERN CALIFORNIA OFFICE: 1010 South Flower Street, 5th Floor, Los Angeles, CA 90015 Phone 213 744-1656 Fax 213 748-2432

- Long-term care
  - Preliminary elements of a social insurance scheme for long-term care should be put in place at the time a proposal is passed.
  - A phase-in process must be clearly defined and must identify eligibility, benefits and financing.
  - Benefits should include home and community based care with an emphasis on least restrictive alternatives.

<u>QUALITY OF CARE AND CHOICE OF PROVIDER</u>

- Individuals should be able to choose freely amongst private and public health plans and appropriate health providers.
- Health plans and health providers should compete on the basis of quality and without additional costs to consumers.
- Care should be culturally appropriate and linguistically accessible.
- Care should meet the individual health and social needs of people with disabilities or with chronic or unusual medical needs.
- Health plans and health providers should be routinely evaluated to measure quality of care and information should be readily available to consumers.

<u>AFFORDABILITY FOR EVERY INDIVIDUAL AND FAMILY</u>

- An annual budget cap should be established for all health care resources to limit overall health spending.
- The budget should be determined through a publicly accountable process.
- Wasteful administrative procedures, unnecessarily duplicated technologies and inappropriate services should be eliminated.
- Care should be provided by appropriate providers in appropriate settings.
- Financing should be based on ability to pay.

Chairman STARK. Thank you.
Mr. Kirsch.

STATEMENT OF LARRY KIRSCH, PRESIDENT, CONSUMER HEALTH ADVOCATES, INC., BOSTON, MASS.

Mr. KIRSCH. Thank you, Mr. Chairman.

Thanks for the opportunity to appear here today to discuss the crucial issue of State health insurance regulation. I have been asked to pose the question: How well are the States doing now, and will they be able to do more in the future to serve consumers?

For the record, I am Larry Kirsch, president of Consumer Health Advocates, and for the past 15 years my small nonprofit organization has been assisting consumer groups, seniors, trade unions and State and local agencies around the country deal with matters relating to health insurance regulation.

Among other things, we have worked on rate regulation, the framework for new insurance products, such as long-term care insurance, solvency protection, market conduct and consumer protection. During this time, we have participated in two dozen health insurance ratemaking proceedings, conducted research and provided technical assistance and training in more than a quarter of the States. In many instances, we have assisted State insurance departments directly; in others, we have worked with State attorneys general, public advocates and consumer groups before State insurance regulators.

Perhaps the most constructive contribution I can make this morning is to organize and highlight some working impressions about the current state of health insurance regulation. These comments reflect my personal observations and experience, rather than the results of academic study, and I hope they will be understood in that light.

While my specific comments will point to certain flaws in State regulation, I would like to make a couple of general observations upfront. First, many of the imperfections I will address are remedial. Some have already been recognized and conceded, and others have not.

I would like to think that the efficacy of State insurance regulation would be judged in part in terms of its capacity for self-reform, and I would hope this subcommittee would attempt to keep accurate score.

Second, in the spirit of Mark Twain, I personally think the report of the demise of State insurance regulation is still premature. I happen to believe that the States as laboratories argument is quite plausible in the fast-moving health insurance environment, but I am perfectly prepared to evaluate new competing arrangements, particularly those blending Federal standards with a certain degree of State flexibility, along the lines that you have been discussing this morning, Mr. Chairman.

Turning now to specific observations, I would like to make a comment briefly on three topics: solvency, the scope of State regulation, and rates.

First, solvency: The public equates insurance regulation with solvency protection. It is what policyholders think insurance departments do. In my experience, financial surveillance staffs too often

represent the weakest element of the regulatory apparatus, rather than their highest achievement. This is true in the number of smaller, poorly funded departments, but it is equally true among some of the largest, best-funded and most sophisticated agencies among the States.

I believe this problem has been recognized and is being addressed to a degree through the NAIC accreditation process, but I tend to agree with the GAO that the accreditation process in its current form is too timid and has other serious flaws.

The nub of the problem, in my judgment, is that the accreditation standards rely excessively upon the legal authority and capacity of the departments to police insurers, and do not adequately measure actual performance itself. For example, the standards require that the States have the authority to establish minimum levels of capital and surplus, but stop short of declaring precisely what those minimally safe and acceptable levels should be.

The same is true for liability and reserve accounts. As for guaranty fund protection, the standards mandate some form of coverage, but they do not say who must be in the fund, for example, should the Blue plans and HMOs be included. Nor do they prescribe specific levels of minimal financial protection for policyholders.

The troublesome question is whether the authority and capacity of the States to regulate solvency translate adequately into actual financial safety for health insurance policyholders nationwide. At best, I am agnostic about this equation, and for that reason would far prefer an accreditation that was mandatory in the States and was structured on a performance, rather than a capacity basis.

I tend to think that structural and cyclical trends inherent in the health insurance industry now are likely to impose increasingly severe challenges for regulatory authorities over the next several years and, hence, believe that it is too late in the day to phase in solvency regulation on a gradual, incremental basis over some extended period of time.

I would like to turn now to the scope of health insurance regulation. New and hybrid risk-bearing formats are cropping up with growing regularity, putting great pressure on State legislatures and regulators to keep pace. In addition, powerful incentives driving insurance entities to sidestep effective state oversight place ordinary policyholders at increasing jeopardy with respect to solvency and other central features.

Several examples will illustrate these points. This morning you alluded to one, namely guaranteed loss ratio products for individual policyholders which have recently been approved by several legislatures on the theory that the insurer is obligated to rebate all excess earnings to policyholders. Early experience with this format, however, has demonstrated a tendency for guaranteed loss ratio insurers to heavily medically underwrite prospective insureds and to increase renewal premiums by 50 percent or more.

Deregulation of health insurance has taken any number of routes. The most prevalent, of course, is ERISA-preempted self-insurance. Less well publicized modes of deregulation include the conversion of Blue plans from heavily regulated public benefit status to minimally related mutual status. And recently, in one State

that I believe you referred to this morning, Mr. Chairman, the transfer in regulatory jurisdiction over a Blue plan from the State insurance department to a lightly regulated department of corporations.

Turning to rates, States differ widely in their approach to health insurance ratemaking. The GAO documents major variations in both the legal format governing rate approval or disapproval and the type and amount of resources that the individual States apply to the process. Our experience confirms these findings.

The additional point I would like to make has to do with the potential power of ratemaking for health care cost containment and efficiency. Consider the case of Blue Cross.

In those States requiring the prior approval of Blue Cross rates for individual, small group and/or medigap business, the method and intensity of review, the review process itself and the criteria for approving rate requests differ considerably. Some tend to be relatively informal, almost conference-like, with the main issues focusing on the projection of trends and the distribution of proposed rate increases by line of business. At the other end of the spectrum, some States hold trial-type rate hearings, with multiple intervening parties and a broad ranging agenda.

While the various formats clearly have their respective strengths and weaknesses, it has been my experience that those that work hardest to establish substantive approval criteria and that probe the rate justifications most critically tend to be more successful.

As an example, one State requires that its Blue plan demonstrate the effectiveness of its portfolio of cost containment initiatives, before any rate relief can be approved. The burden falls on Blue Cross to demonstrate the salutary impact of its programs on cost and utilization trends. And on more than one occasion, this insurance department has found noncompliance sufficient to justify the outright denial or very substantial reduction of requested rates.

In conclusion, Mr. Chairman, I am truly awed by the objective difficulties inherent in the insurance regulators' job and dismayed by the obstacles often placed in the path of those working hardest to protect the consumer and greater public interest. I suspect that the immediate future will pose even greater challenges and will require the States to accelerate many needed reforms, only a few of which could be addressed here today.

As part of the process, I would expect the overall structure and performance of insurance regulation to come in for critical appraisal, and I count myself among those who would not be at all opposed to an objective analysis of the options.

Thank you.

[The prepared statement follows:]

Testimony of Larry Kirsch
Consumer Health Advocates, Inc.
Health Subcommittee
House Committee on Ways and Means
May 27, 1993

STATE REGULATION OF PRIVATE HEALTH INSURANCE

Mr. Chairman and Members of the Health Subcommittee, thank you for the opportunity to appear here today to discuss the crucial issue of state health insurance regulation. I've been asked to pose the question: how well are the states doing now and will they be able to do more in the future to serve consumers? The Subcommittee should be commended for initiating today's inquiry since social control of health financing will clearly be one of the preeminent issues in the coming health care reform debate.

For the record, I am Larry Kirsch, president of Consumer Health Advocates and for the past fifteen years my small, nonprofit organization has been assisting consumer groups, seniors, trade unions and state and local agencies around the country deal with matters relating to health insurance regulation. Among other things, we have worked on rate regulation, the framework for new insurance products such as long term care insurance, solvency protection, market conduct and consumer protection. During this time we have participated in two dozen insurance ratemaking proceedings, conducted research, and provided technical assistance and training in more than a quarter of the states. In many instances, we have assisted state insurance departments, directly; in others, we have worked with state attorneys general, public advocates and/or consumer groups appearing before state insurance regulators.

Perhaps the most constructive contribution I can make this morning is to organize and highlight some working impressions about the current state of health insurance regulation. These comments reflect my personal observations and experience rather than the results of academic study and I hope they will be understood in that context.

To begin with, it is my belief that the tasks facing the conscientious state health insurance regulator today are among the most demanding to be found in state government and are becoming progressively more challenging. The regulator is presently called upon to do triple duty: he or she must serve as a <u>philosopher</u>-- often dealing with extremely subtle ethical dilemmas and questions of competing social values affecting very many lives; he or she must also serve as a <u>technocrat</u> called upon to understand, oversee and proactively intervene in one of the most complex and dynamic industries in the American economy, and also as a <u>public leader</u>, communicating performance expectations to members of the insurance community, businesses, consumers, lawyers and others in a quintessentially political environment.

I salute these regulators, knowing that most of them work very diligently, often in a hostile environment, without benefit of copious resources or favorable daily recognition.

And while my specific comments will point to certain flaws in the regulation of health insurance, I would like to make a couple of general observations up front: first, many of the imperfections I will address are remediable; some have already been recognized and conceded; others have not. I would like to think that the efficacy of state insurance regulation would be judged, in part, in terms of its ability to be self-reforming. And I would hope this subcommittee would attempt to keep an accurate scorecard. Second, in the spirit of Mark Twain, I personally think the reported demise of state insurance regulation is still premature. I happen to believe that the "states as laboratories" argument is quite plausible in the fast moving health insurance environment but am perfectly prepared to evaluate new, competing arrangements, particularly those blending Federal standards with a certain degree of state flexibility.

Turning, now, to specific observations, I would like to comment briefly on three topics:

- Solvency
- Scope of regulation
- Rates

SOLVENCY

The public equates insurance regulation with solvency protection. It is what policyholders think insurance departments do. Yet in my experience, financial surveillance staffs too often represent the weakest element of the regulatory apparatus rather than their highest achievement. This is true in a number of smaller, poorly funded departments, but it is equally the case among some of the largest, best funded, most sophisticated agencies.

I believe this problem has been recognized and is being addressed to a degree through the NAIC accreditation process. But I tend to agree with the General Accounting Office that the accreditation process--in its current form--is too timid and has other serious flaws.

On the positive side, we can say that a third of the states have already been accredited and eighteen more are currently in the pipeline. But having made that observation, it is difficult to discern its real importance.

The nub of the problem is that the accreditation standards rely, excessively, upon the legal authority and capacity of the departments to police insurers and do not measure actual performance, itself. So, for example, the standards require that states have the authority to establish minimum levels of capital and surplus but they stop short of declaring what those minimally safe and acceptable levels should be. The same is true for liability and reserve accounts. As for guaranty fund protection, the standards mandate some form of coverage but they do not say who must be in the fund (e.g. Blue Cross, HMOs); nor do they prescribe specific levels of minimum financial protection for policyholders.

The troublesome question is whether the authority and capacity of the states to regulate solvency translates adequately into actual financial safety for health insurance policyholders, nationwide. At best, I am agnostic about this equation and would far prefer that accreditation were mandatory in the states by a given date (perhaps with standby Federal requirements for non-compliance) and that it were structured on a performance rather than capacity basis. I tend to think that structural and cyclical trends inherent in the health insurance industry are likely to pose increasingly severe challenges for regulatory authorities over the next several years and believe, therefor, that it is too late in the day to phase-in solvency regulation on a gradual, incremental basis.

SCOPE OF HEALTH INSURANCE REGULATION

New or hybrid risk-bearing formats are cropping up with growing regularity in the health financing industry putting great pressure on state legislatures and regulators to keep pace. Even in the most sophisticated states, ostensibly innovative financing arrangements are on a collision course with thoughtful regulation. In addition, powerful incentives for insuring entities to sidestep effective state oversight place ordinary policyholders at increasing jeopardy with respect to solvency, termination, rates, marketing and other central features.

Several examples will illustrate these points:

Guaranteed Loss Ratio ("GLR") products for individual health policyholders have been approved by legislatures and regulators in several states based on the attractive claim that the insurer is obligated to return excess earnings to policyholders through premium reductions. Early experience with this format, however, has demonstrated a tendency for GLR insurers to heavily medically underwrite prospective insureds and to increase premiums on renewal by fifty (50) percent or more.

Mass Marketed, celebrity-endorsed, individual products written through group trusts domiciled in several states are still out there reaching millions of consumers over cable TV, through the mail and in advertising supplements. Many insurance departments question the inherent value of some of these products and are critical of their marketing. Yet most state health insurance laws make it virtually impossible for regulators to circumscribe this activity because of limitations in so-called extraterritorial jurisdiction. One state regulator did successfully prohibit the sale of certain mass marketed products after an arduous legal battle but that experience no doubt chilled other states.

Deregulation of health insurance has taken any number of routes. The most prevalent, of course, include ERISA-preempted self insurance for single and multi-employer groups. Less well publicized modes of deregulation include the conversion of Blue Cross Plans from heavily regulated, public benefit status to minimally regulated mutual status. And, recently the transfer in regulatory jurisdiction over a Blue Plan from the state insurance department to a department of corporations.

In my judgment, it is profoundly important for there to be public confidence in the supervision of the private health insurance marketplace. It is vital that consumers have and know that they have strong and effective watchdog agencies who are setting and enforcing equitable rules of play. It is extremely disconcerting, therefor, to see the erosion of traditional social controls in this industry without a demonstrated, effective substitute. While it is beyond the scope of my testimony, this morning, to suggest specific remedies, I would like to underscore the point I made before, namely, that the health insurance market over the next several years is apt to become more perilous-- before it shakes out in one form or another--thereby raising the stakes for effective public supervision.

RATES

States differ widely in their approach to health insurance ratemaking. The GAO documents major variations in both the legal format governing rate approval and/or disapproval and in the type and amount of resources that the individual states apply to the process. Our experience confirms these findings.

The additional point I would like to make has to do with the potential power of ratemaking for health care cost containment and efficiency. Here I will draw from experience with Blue Cross-Blue Shield ratemaking in five states.

In those states requiring the prior-approval of Blue Cross rates for individual, small group and/or Medigap business, the method and intensity of review, the review process, itself, and the criteria for approving rate requests differ considerably. Some tend to be relatively informal--almost conference-like--with the main issues focusing on the projection of trends and the distribution of proposed rate increases by line of business. Often, these rate filings are handled through an informal, negotiated settlement between the Blue Plan and the regulator. At the other end of the spectrum, some states hold trial-type rate hearings, with multiple intervening parties, including representatives of affected consumers; highly detailed rate filings and exhibits and the introduction of expert testimony on a variety of issues. These may be settled by a stipulation among the parties but most frequently are not.

While the various formats clearly have their strengths and weaknesses, it has been my experience that those that work hardest to establish substantive approval standards and that probe the rate justifications most critically tend to be more successful. As an example, one state requires that its Blue Plan <u>demonstrate the effectiveness</u> of its portfolio of cost containment initiatives before any rate relief can be approved. The burden is on Blue Cross to demonstrate the salutary impact of its programs on cost and utilization trends. And on more than one occasion, this insurance department has found non-compliance justifying the outright denial or substantial reduction of requested rates. Effective remedial steps were instituted and have evolved over time in response to the potential threat of rate disapproval.

Another department has followed a rate intervener's

attack on Blue Cross' administrative costs with an order for a comprehensive, independent audit in which the intervener may actively participate.

Yet a third department accompanied its rate decision with a detailed set of supplemental orders requiring Blue Cross to perform specific actions such as reforming its hospital contracts. The department's authority to enforce these orders was upheld by the state's highest court.

The principal lesson I draw from these examples is that the ratemaking process can, but more often than not, fails to reach beyond the simple observation of health care costs. State departments can use the process, strategically, to influence the behavior of insurers, and through them, of health care provideres, in order to influence the cost-effective delivery of care.

CONCLUSION

In conclusion, Mr. Chairman, I am truly awed by the objective difficulties inherent in the insurance regulators' job and dismayed by the obstacles often placed in the path of those working hardest to protect the consumer and greater public interest. I suspect that the immediate future will pose even greater challenges and will require the states to accelerate many needed reforms, only a few of which could be addressed here, today. As part of the process, I would expect the overfall structure and performance of insurance regulation to come in for critical appraisal and I count myself among those who would not be at all opposed to an objective analysis of the options.

Once again, Mr. Chairman, I appreciate the invitation to appear before the subcommittee this morning and I am prepared to take your questions.

Chairman STARK. Thank you, Mr. Kirsch.
Mr. Hunter.

STATEMENT OF J. ROBERT HUNTER, PRESIDENT, NATIONAL INSURANCE CONSUMER ORGANIZATION, ALEXANDRIA, VA.

Mr. HUNTER. Mr. Chairman, thank you.

My name is Bob Hunter. I am president of the National Insurance Consumer Organization, and formerly served as Federal Insurance Administrator under Presidents Ford and Carter.

You asked about the GAO report, and I missed what the others said, because I was in another hearing, so you are going to get a very fast solo reaction, having just read it.

The GAO report looks like it borrows from other earlier reports, but the conclusions ring true to me and are consistent with work I have done myself and, therefore, I don't find any problem with the fact that it doesn't look like a startup from scratch type of job to me.

For example, I worked with Esther Peterson and Steve Brobeck, of Consumer Federation of America, and Joan Claybrook of Ralph Nader's Public Citizen, to study resources and capacity, as well as independence, of the State insurance departments, and we have issued reports on that.

In 1991, we reviewed the capacity of State insurance departments, and we issue a report in 1992 finding that only 11 States met what we believe were the minimum requirements for budgets.

Fully half of the money spent on State regulation was spent in only four States, California, Florida, New York, and Texas. They also have half of the employees working in State regulation. No State has as many employees as they have insurance companies to monitor. The top 4 States have fewer than 2 companies per employee, but the next lowest is 4.6, and New Mexico has as many as 250 companies per employee to monitor. Some 11 States employ no actuary, and another 11 have only 1 actuary. I did a quick count in the GAO report and it looks like about 40 actuaries are health insurance actuaries, of the 160 actuaries employed in State regulation.

In a typical State, there are 1,444 companies to monitor, of which 162 are headquartered in the States. Only 20 market conduct examinations per State were completed in 1991. Only 62 financial examinations were completed. Some States have adequate resources for regulation, but the vast majority of States do not. The result is that there are such problems as only a few rate hearings in most States, even the States requiring prior approval, for example.

As to regulatory independence, we issued a report in February 1990, finding that 37 percent of insurance commissioners came out of the insurance industry, and half of the insurance commissioners go back to it. This revolving door problem led us to recommend a 1-year prohibition against employment in the insurance industry after serving as a State insurance commissioner. To my knowledge, no State has adopted that recommendation.

The tenure of the typical insurance commissioner is a problem. It is very short. The average tenure is 3.3 years, much longer with elected than appointed commissioners, however. Both the funding and other capacity measures and the independence of State regu-

lators of insurance have been improved significantly in recent years, but it still falls far short of what it should be.

The National Association of Insurance Commissioners has changed and made itself better, I think. It now funds 17 consumer representatives to attend its quarterly meetings. That is still quite a bit below the 1,000-plus insurance attendees at each meeting, but it is a step forward. The NAIC has done away with its advisory committees in order, as they put it, to get away from industry dominance.

But even with the improvements, there are serious questions as to the capacity and the will of State insurance regulation to control health insurance rates or health insurance companies. The States have had significant control over health insurance in the past, at least until ERISA gave them some problems, and States have not fixed health insurance, as witness the Federal Government having to work on it.

Even States with resources, a commissioner with experience, and a will to do what is right have a problem which is called the State legislature. Frequently, the insurance committee of the State legislature is made up significantly of insurance agents and insurance executives and lawyers with insurance clients. It is very hard, if not impossible, to move pro-consumer legislation at the insurance committee level in a lot of States.

Even with all its warts, however, I favor State regulation over Federal regulation of insurance. We have made a lot of progress in recent years and States are becoming more accountable. But national health insurance is something else. It is the only insurance every American needs. Real reform requires powers far beyond what insurance commissioners possess, enforcing budgets, disciplining doctors, saying no to hospitals and so on.

National health insurance must be national. From other countries, we know that national approaches work. That is why I support the well-tested and workable single-payer approach. It will cost too much to keep insurers in the game. Their overhead and the need for layers of regulation are part of the reason managed competition will fail.

I would be appalled if the White House punted tough questions on health insurance reform to the States. If they do, in the name of flexibility, I fear an outcome that will be anticonsumer. While a few States have regulatory resources to do the job, only a subset have the will to do it properly, and even those will be subject to being overruled by their State legislatures. Any health insurance delegation to the States must be extremely tightly defined and strict oversight by a Federal agency included as part of a national bill.

Thank you.

[The prepared statement follows:]

TESTIMONY OF J. ROBERT HUNTER
NATIONAL INSURANCE CONSUMER ORGANIZATION

Mr. Chairman and members of the Subcommittee, I appreciate your invitation to testify before you this morning.

You have asked for comments on the capacity of states to monitor and supervise health insurers. In this testimony, I will first comment on state insurance department capacity to regulate as measured by work I participated in as part of the Consumer Insurance Interest Group (the other members are Esther Peterson, Joan Claybrook of Public Citizen and Stephen Brobeck of Consumer Federation of America). CIIG worked with the Professional Insurance Agents (PIA) in producing several reports.

Secondly, I will comment on regulatory will.

Finally, I will comment on state legislative issues.

Insurance Department Resources

The most recent CIIG report on resources of state insurance departments was issued in June, 1992.[1] The findings of our report were:

* 1991 Insurance Department Budgets ranged from $757,000 (South Dakota) to $89 million (California). The average state budget for the insurance department was $9.8 million. The budgets of four states -- California, New York, Florida and Texas -- represented half of the budgets of all states.

* CIIG's standard for adequate funding of insurance departments (budget equal to or greater than 10% of premium taxes collected) was met by only eleven states.

* No state has as many employees as insurance companies to monitor. While the four largest states have less than two admitted companies per department employee (the lowest is Florida at 1.3), no other state is lower than 4.6 companies per employee. New Mexico had the highest ratio, 250.7 companies per employee. (Note: our count of employees include clerical and others not classified as professional staff.)

* Staffing ranged from 22 (Vermont) to 1,260 (Texas). The top four states had half of the employees.

* There were 161 actuaries (those professionals that understand the mathematics underlying insurance prices) at state insurance departments, but eleven states had no actuary at all and another eleven had only one (whether the actuary was life/health or property/casualty was not asked).

* In the typical state there are 1,444 admitted insurance companies, of which an average of 162 were domiciled (i.e., headquartered) in each state.

* The typical state performed 20 market conduct examinations (fourteen states completed no market conduct examinations in 1991).

* The typical state completed 52 financial examinations (every state completed some of these, Maine completing the least -- 5).

These findings lead us to conclude that some states have adequate resources for regulation, but most do not. As a result we recommended that states raise their budgets, increase coordination and hire many more actuaries. The states are stressed to handle

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[1] The Adequacy of Resources Available to State Insurance Departments, CIIG and PIA, June, 1992.

what they have on their plates today.

Insurance Department Will

As our report concluded, "Adequate resource levels are not the only condition of effective insurance regulation, but they are necessary for effectiveness."[2]

The question of will of a regulator is difficult to measure. CIIG tried to get at part of it in a report issued in February of 1990.

We found that 37% of insurance commissioners come out of the insurance industry and half (49%) worked in the insurance industry after employment. This "revolving door" problem concerned us enough to recommend that state insurance commissioners be barred from working for insurance companies for at least a year after they leave office. This proposal has not been acted upon by the NAIC or individual states.

We also were concerned with frequent turnover. Twenty percent of the commissioners we tracked served less than two years, the average commissioner only 3.3 years. The tenure of commissioners is too short for effective regulation to occur.

In our press release accompanying the study, CFA's Mr. Brobeck said "The study reveals two areas of concern. One, the short period of time many commissioners served; and two, the number of former commissioners who immediately moved to the industry after leaving office. These concerns raise questions about the adequacy and impartiality of decisions made in office."

Concerns about a too cozy relationship between insurers and their regulators is not new. The General Accounting Office reported it in its major report on state regulation issued in 1979[3], as follows:

> **"GAO found that insurance regulation is not characterized by an arms-length relationship between the regulators and the regulated. While the extent of the "revolving door" problem may be overstated by critics of State regulation, about half of the State insurance commissioners were previously employed by the insurance industry and roughly the same proportion joined the industry after leaving office. The meetings of the National Association of Insurance Commissioners are numerically dominated by insurance industry representatives. Its model laws and regulations were drafted with advisory committees composed entirely of insurance company representatives."**

I have observed that there has been some improvement in both the funding of state regulation and in the quality of regulation, but it is still a long way from what it should be.

Besides individual state improvement, the NAIC has improved itself recently. It started funding consumer representatives for their expenses of attending the quarterly NAIC meetings. There are now 17 funded consumer representatives. The last meeting, in Nashville, was the last meeting at which insurers funded parties, lunches and trips (such as steamboat rides) for the regulators were allowed. For some years now the NAIC has allowed consumer representatives on its advisory committees, albeit always greatly outnumbered by insurer representation. Now, advisory committees have been abandoned by NAIC in order to break away from insurer dominance.

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[2] Ibid, Page 11.

[3] <u>Issues and Needed Improvements in State Regulation of the Insurance Business,</u> October 9, 1979.

But, even with this improvement, there are serious questions about state regulation of insurance that must not be overlooked, including the obvious fact that the current system of health insurance which we seek to reform was developed under state supervision. Try to name one state that has fixed health insurance. I can not.

We still need a tough model bill on ethics for insurance commissioners and staffs and we need better consumer participation in state regulatory and legislative deliberations.

State Legislature

State legislative committees that deal with insurance very often are dominated by the insurance industry. The following quote rings true to me after decades of working at the state level:

> **"Lobbyists hang around all fifty state capitols looking after the insurance industry's interests. Not all work at it full time; many represent other clients as well -- but they're there when they're needed. Take Massachusetts. Massachusetts had, in all, 400 men and women registered as "legislative agents" in the first quarter of 1981. There was a man representing the Massachusetts Cosmetologists Association, two representing Common Cause, two for the President and Fellows of Harvard college. The tobacco institute had a man on retainer; Ford, General Motors and General Electric each had one. The state's banks and utilities and labor unions had two or three dozen each. The insurance industry had sixty.**
>
> **Insurance lobbyists outnumber all others in virtually every state. "Our strength?" pondered one. "[It] comes from having a group of people who tell a story that is logical and reasonable to a group of people who don't have the slightest idea what you're talking about."**
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> **It comes, too, at least in some instances, from the assistance lobbyists may occasionally provide in obtaining loans and mortgages and insurance, and (for those legislators who are attorneys) in settling insurance claims. Discussing an upcoming vote, a lobbyist was told to expect a certain legislator to vote against the industry. "Oh no," he replied, "I've helped that one settle too many cases."[4]**

It is my experience that insurers can, pretty much, get what they want from state legislators. On several occasions, as we have tried the difficult task of obtaining regulatory approval for lowering the outlandishly high credit life insurance prices, the legislature has overruled the rare regulator with the courage to act by rolling rates back up or removing price regulation authority from the commissioner.

Conclusion

Although you may not be able to discern it from the previous discussion, I generally favor state regulation of insurance, even with all its warts. As I said earlier, it is improving. Consumers have, particularly since passage of Proposition 103 in California in November, 1988, been making real progress in several states.

The federal government regulatory option is not without serious concern. I couldn't imagine, for example, consumers sending complaints to some federal bureau. I have opposed Chairman John Dingell's moves on federalizing much of solvency regulation, except for off-shore insurers and reinsurers beyond the reach of state regulation.

National health insurance is something else, however. For one thing, health insurance is the only insurance every American needs. Real reform requires budgeting

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[4] Invisible Bankers, Andrew Tobias, Linden Press, 1982, Page 34.

and intrusive cost controls, the need for significantly more efficient delivery mechanisms, the ability to monitor doctors and say "no" to hospitals when hospitals want too many new gadgets. National health insurance should be, in a word, national. We know that approach works from experience in other countries.

I believe only a single payer plan will ultimately work for America. Managed competition will fail, in my view, because it will simply cost too much to keep the big insurers in the game. Putting control of insurers in the hands of the states would make cost control even more difficult, with another layer of bureaucracy to sort through.

I would be appalled if the White House "punted" some of the tough questions on health insurance reform to the states. I imagine that the states and the big insurers support this idea, the former out of "turf" considerations, the latter out of bottom line consideration, but it would be awful for America.

In my view, putting the states in charge of anything with any real flexibility will assure an outcome most favorable to insurance companies and most intolerable for consumers of health insurance. While a few states have the regulatory resources needed, even fewer have the will to do what is right and even those are subject to being overruled by their state legislatures. Any health insurance delegation to the states must be extremely tightly defined and strict oversight by a federal agency included as part of the national bill.

Thank you. I'd be pleased to respond to any questions you might have at the appropriate time.

Chairman STARK. Thank you.

It appears to me that there are only three parties to this, three actors in the opera: first, the providers of medical care, second, recipients; and third, what I will loosely define as the intermediaries. Those are co-ops, privately owned insurance companies or the Veterans Administration. I think that pretty much outlines or defines the groups.

Now, I would expect that you all represent the interests of the beneficiaries. But, can any of you think of any reason or any case in which the interests of the beneficiaries ought not to be the primary concern of both the Federal and State government? Is there any scenario that I miss that we ought to be concerned about the other groups insofar as—I would hasten to leave out the licensing of physicians, for instance, which I stipulate that either insurance commissioners or Congress is not able to do. Other than that——

Ms. O'SULLIVAN. Certainly, consumers should be at the center of all thinking that goes on about this. It should be what is in the consumers' best interest, not what is in somebody else's financial self-interest. To the extent that protecting the financial self-interest of an entity best serves consumers, then you want to make sure you are doing that.

Mr. HUNTER. Sometimes, of course, that comes into a little bit of pulling, because, on the one hand, you want the lowest rate, and, on the other hand, you want a solvent insurer. So there are obviously times we have to worry about the insurers from some point of view, but through the context of taking care of the consumer.

Chairman STARK. Let's take groups, HIAA, Blue Cross, various offices of insurance commissioners. Do you want to guess how many people in those organizations or what percentage of their employees, resources or salary is devoted to responding to complaints or concerns of beneficiaries, as opposed to what percentage is concerned with lobbying legislatures and dealing with providers?

Ms. O'SULLIVAN. They may be using a lot of people to respond to consumers to deflect their complaints, not so much to sincerely respond to them, I would say. I don't know what the number is. I know that a tremendous number of our dollars, as people who purchase insurance, end up going into lobbying activities that are, in fact, lobbying against our self-interests as purchasers of insurance.

Mr. HUNTER. The lobbying costs are usually not broken out as a separate item in a rate filing, although occasionally they are and sometimes even disallowed. California has started to do that.

Chairman STARK. If you look at my campaign contributions, you can get a good idea.

Mr. HUNTER. The insurance commissioners, some of them anyway, spend quite a bit on answering complaints. California, I believe, have as many as 100 employees working on just complaint handling.

Ms. O'SULLIVAN. The department of insurance.

Chairman STARK. Do any of you have any statistics that you can recall in general as to the number of cases or complaints that you all deal with through your organizations or any groups you have worked with? Are any of you so accessible that you get a large number of referrals?

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Ms. O'SULLIVAN. We get a lot of calls, but not in the thousands.

Chairman STARK. Mr. Kirsch.

Mr. KIRSCH. We primarily hear from seniors particularly with respect to their policies.

Chairman STARK. I want to come back to that in a minute.

Mr. Hunter.

Mr. HUNTER. We get probably on the order of 2,000 to 3,000 complaints a year compared to 344,000 complaints a year, according to the GAO study, received by insurance departments. We usually refer people to insurance departments in our literature, because that is the source where they can get some relief, perhaps.

Chairman STARK. What I am curious about, Mr. Kirsch, how many of your complainants have a complaint with Medicare?

Mr. KIRSCH. It depends on——

Chairman STARK. Not the supplemental, but with——

Mr. KIRSCH. It depends on how you define complaint. People have a lot of questions about Medicare.

Chairman STARK. I understand.

Mr. KIRSCH. They keep on receiving their EOBs and don't fully understand what they mean. Or they file part B benefit claims and are get information which they just can't reconcile with their own records. Is that a complaint? When you begin to investigate, sometimes it is, sometimes it isn't.

Chairman STARK. Denial of service?

Mr. KIRSCH. Denial of services or just questions about did I receive the appropriate reimbursement for the doctor bill, I still have X amount out of pocket, et cetera.

Chairman STARK. Are you aware of any areas where they didn't receive what the law requires?

Mr. KIRSCH. Obviously, from time to time there are some glitches or at least there are some gray areas, but I would agree with you, if the implication is that there are relatively few. I think that is true.

Chairman STARK. Mr. Hunter, how many out of your 1,000?

Mr. HUNTER. I would say about one-third of them are health related, one-third auto and one-third everything else. I don't remember, as I sit here, any on that. If there were, there was just a handful.

Ms. O'SULLIVAN. We conducted a campaign called "I Thought I Was Covered," and the idea was to take these stories and get them out to the public. So when people would call us, we would turn around and let the media and other people, elected officials and so on know about them. They fell into the following categories, most of the complaints, anyway: Discrimination based on preexisting conditions, discrimination based on occupation, denial of benefits for services believed were covered, refusal to pay claims, unreasonable escalation of premiums, imposition of caps and these divide and dump practices. Those were most of the private insurance complaints.

Chairman STARK. How about Medicare, did any of——

Ms. O'SULLIVAN. I hear more, as Mr. Kirsch mentioned, people confused, overwhelmed by paperwork. Those are the things we hear about Medicare.

Chairman STARK. I guess what I am getting at is that, just in defense of whatever Federal regulation may come out, we don't do too bad a job. I get a lot of complaints from doctors saying that they are not getting paid enough, a complaint hardly concurred with by public feelings at this time, and a lot of threats from hospitals that they will go broke. I put that in the same category with my kids threatening to hold their breath and turn blue and die. It just has never happened.

What I am concerned about is that it makes sense to you that your concern for the beneficiaries goes jumping ahead to the advent of health purchasing cooperatives or HIPCs or whatever they are going to be called. Would you share my concern that these might be dominated by the interests of provider and intermediaries, with precious little attention paid to the beneficiaries? Do you have any other experiences with operations of this type that would support that concern?

Mr. HUNTER. I raised that issue with Ira Magaziner, because I——

Chairman STARK. What did he say?

Mr. HUNTER. He said that if these HIPCs are not controlled and operated and run by the consumers, then the plan would fail. It had to not become captive, and I said how are you going to do that, where are you going to get the experts? He had a little difficulty answering that question, in my view.

Chairman STARK. Let me ask you this: If it is going to be a political operation, I mean the Governors or legislators are going to create these things, how would you make it not be a political operation?

Mr. HUNTER. That was my question. It has been my view that even the regulators sometimes can become captive, much less something that is working with insurers in a cooperative way. The closest thing I could come up with to the HIPC was the Office of Personnel Management running the Federal plan here, and my view is that the data they put out on quality of care is zero, the data they put out really that is helpful, on price and so on, was very low. I used to put pressure on them when I was in the Government to improve that.

Thank goodness, Checkbook and people like that are putting out really helpful price information, but Office of Personnel Management should have done so itself. In my view, these PCs are an Achilles heel to any managed competition working, unless they can really be kept consumer controlled and expert, which is tricky, because if they have to rely on the insurers and the providers for all their data and all their information and don't have actuaries and don't have——

Chairman STARK. You are talking about the quality of the providers, are you not? And to the extent you are in an indemnity plan—I don't know that even Checkbook can tell you—you have to go pick the doctor. I would admit that we have precious little information to give people, even if they wanted to go doc shopping.

Mr. HUNTER. But there is more than indemnity plans in the Federal program. There are HMOs and PPOs.

Chairman STARK. But it is not a very large percentage of the folks who sign up.

Mr. HUNTER. Still, there is no good information.

Chairman STARK. That is true, in our fair State, in my county, Alameda, the home of dumping. I guess in your eyes, Ms. O'Sullivan, you think it should be a felony to dump?

Ms. O'SULLIVAN. Absolutely, yes.

Chairman STARK. How severe? Life?

Ms. O'SULLIVAN. People die. I mean, in Alameda County, people—people we were able to record and——

Chairman STARK. Do you know what manslaughter provides in California? It is not the chair or the gas chamber, but——

Ms. O'SULLIVAN. I do not want to get into death penalty discussions.

Chairman STARK. Yes, I do not see any reason. I have often felt that would have a meritorious effect on the accessibility of health care in many communities, but that may be harsh.

Half the people in Alameda County belong to Kaiser, who have, I think, escaped—except recently because of their union beef—but I think they have escaped severe criticism relative to other HMOs. Even they will admit, for instance, in HPICdom the prize bull is the State CalPERS plan, and Kaiser will say quite frankly that the way they held their prices down for CalPERS is to cut benefits, not a very astounding way to save money. I mean, that does not take a stroke of genius to figure out how to save money cutting benefits.

But I am concerned when you get into this, and you mentioned it. The underutilization issue is one which I do not think anybody has any ability to regulate. As far as I know, we have a whole stable full of hound dogs over there in HCFA who are overutilization experts. They can determine it; they can spot it; they can penalize it; they can try and eliminate it.

I am afraid if we go to somebody and wave our wand and say: Now everybody is in an HMO; you are going to stop the rabbit on that dog track, and they are going to trip all over each other. You have got a guy with 30 years experience slapping the overutilizers, and now you say: OK, Henry, back to work tomorrow morning; you are going to be in charge of shooting all the underutilizers.

Ms. O'SULLIVAN. But we have got an outrageous situation in this country. We are spending 14 percent of our gross national product on health care and pretty much do not know much about what we are doing or what the outcomes are, whether or not that money is wisely spent or not.

The places we do have outcomes—and you can look at things like life expectancy; you can look at infant mortality rates; we do have some data about how we are doing as a nation—we are doing very poorly with those dollars.

One of the things I think that the Federal Government needs to do is set some really clear parameters about what kinds of data you want collected and what we are going to be looking at, so that we can begin to compare quality amongst the managed care systems.

Chairman STARK. The best we are going to be able to give you in this decade is a database, if we could get that far. We cannot even agree on what the protocol ought to be.

Ms. O'SULLIVAN. Right.

Chairman STARK. Then you are going to have to go—I mean, we have 10 years to sort that out, and plus outcomes research, the outcomes are not valid, so you have to wait 5 or 10 years.

Ms. O'SULLIVAN. And I think that this takes us right back to the question about——

Chairman STARK. That is not the issue here. I mean, it is urgent, and it is important. But we have got to deal with the possibility, the likelihood, of a whole new ballgame with $950 billion being funneled arguably, if the Jackson Hole Gang have their way, through five or six big companies. That is a lot of change. It does not take much skimming of that cream to make a lot of money.

Mr. KIRSCH. Can I just——

Chairman STARK. Yes.

Mr. KIRSCH. I am sorry. I just wanted to go back to something that you had raised before. You triggered my thinking about this. You were talking before about what the appropriate roles of the Federal Government would be vis-a-vis the States.

The example that came to mind pertained to the spinoff from a Blue plan in California of a publicly traded company. I happen to think that that such corporate spinoffs may be the wave of the future and that is of concern.

Chairman STARK. The only thing that makes me happy about that is that I think that people who bought stock in those turkeys are going to get stuck big, and I am just going to stand and go: Hooray! You know, sooner or later, what goes around comes around. And, you know, that may be poetic justice.

Mr. KIRSCH. It seems to me that there is a role here for the Feds, and I have not exactly thought it through all the details, but I addressed this problem before the NAIC at its last meeting down in Nashville.

To the extent that the health care business of the future is more economically concentrated and that subsidiaries such as California Blue Cross' Wellpoint Network are going to operate out of the State, it strikes me that new methodologies for controlling this business need to be developed. Unfortunately, the States have no capacity, or very little capacity, to do that right now.

State Insurance Departments using the Insurance Holding Company Act nominally have the authority to regulate anticompetitive practices, but in actuality the antitrust component is cumbersome and unworkable. And to think that State Attorneys General are going to do that stretches the imagination. Few have the capacity.

So it strikes me that there is a role for the Federal Government in terms of regulating the economics of the health care financing marketplace.

How that integrates with the States, I am not clear, but I just would suggest to you, Mr. Chairman, that this is an area that the States are not adequately prepared to deal with right now.

[The following was subsequently received:]

Consumer Health Advocates

June 1, 1993

Hon. Fortney Stark
House Ways and Means Committee
Health Subcommittee
1114 Longworth Building
Washington, D.C. 20515

Dear Mr. Chairman:

In my appearance before the Health Subcommittee on May 27, I referred to a presentation to the NAIC dealing with Wellpoint Health Networks. I enclose a copy of that presentation for the record.

If you have any questions, please feel free to contact me.

Yours truly,

Larry Kirsch
President

One Boston Place
Suite 2630
Boston, MA 02108
(617) 720-0162

CALIFORNIA BLUE CROSS AND WELLPOINT HEALTH NETWORKS

A PRESENTATION TO
THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Special Committee on Blue Cross Plans
Nashville, Tennessee
March 8, 1993

Introduction

I wanted to draw your attention this afternoon to a very recent event in the Blue Cross-Blue Shield arena, namely the creation by California Blue Cross of a subsidiary named Wellpoint Health Networks. The reasons for focusing on this particular transaction as a case study are twofold: the first is that in my opinion Wellpoint represents the leading edge of a trend which raises very significant issues for health policy in general, and for insurance regulators in particular; the second is the hope that presentation of a tangible example like Wellpoint will help this Committee frame and refine the issues inherent in its 1993 charges.

At the outset, let me emphasize that I present the case of Wellpoint for purposes of illustration and nothing more. In the context of this forum, I draw no conclusions about the merits of the Wellpoint transaction: the underlying philosophical and business decisions that motivated California Blue Cross to create it, or the National Blue Cross Association to support it or the California regulators to sanction it. As you will see, some of the issues raised by the Wellpoint transaction are equally relevant to certain stock as well as mutual insurers. So, in sum, I think the case is timely, significant from a public policy standpoint and of general interest.

Background

California Blue Cross very recently spun off its HMO/PPO and certain specialty business to a partially-owned and controlled, publicly traded shell subsidiary of its creation, namely Wellpoint.

According to Wellpoint's initial public offering prospectus, the subsidiary intends to maintain close ties to its parent: among other things, it plans to file a consolidated Federal tax return; to purchase various administrative services from Blue Cross and to file a consolidated financial statement. Of course, it may also issue dividends upstream on the 80 million shares of Class B common stock currently owned by Blue Cross.

Wellpoint currently enrolls almost 2 million HMO and PPO members in California; it expects to extend its in-state services in these and other lines and to expand out-of-state.

Emerging Trends

What developing trends does Wellpoint portend? Let me highlight just two that I think are most pertinent to your mission:

First, Wellpoint is an organizational paradigm of how to separate Blue Cross' private, competitive business from its public benefit lines. As you know, virtually all Blue Plans have been struggling with this same problem: some have gone the mutual route; others have sought legislative solutions like insurance reform; still others are still searching for their particular answer.

The Wellpoint approach is to move California Blue Cross' competitive managed care business into a private, namely stock structure, while leaving the public benefit lines (including individual Med-Sup indemnity) with the parent Blue Plan.

Second is the trend toward ever greater market concentration. Wellpoint clearly positions California Blue Cross to develop and expand its managed care apparatus in-state and out-of-state through acquisition, vertical integration, joint venture and otherwise. While Blue Cross, itself, might have to contend with regulatory resistance or delay, a stock, non-insurer subsidiary can expect to enjoy greater flexibility of action.

Public Benefit vs. Private Business

As I explored the Wellpoint transaction in the light of these emerging trends, a couple of areas of concern bearing directly upon your charges began to crystalize in my mind:

One is the question of separate but equal: in a complex holding company arrangement like this one, do policyholders covered by the public benefit lines achieve equitable treatment? And do insurance regulators have the tools they need to guarantee such treatment?

I would cite three particular issues:

A. Inter-Company Transactions

Inter-company pricing of administrative and other overhead services...i.e the price that California Blue Cross will charge Wellpoint for actuarial, legal, data processing and other services.

I know from firsthand experience just how complex cost-allocation is within a unitary Blue Cross Plan with the usual array of classes and lines of business. To this, Wellpoint adds:

- The possibility of subsidiaries at different levels of relationship with the parent company, i.e. California Blue Cross;

- Subsidiaries which are regulated by a different agency, or are out-of-state and/or not in the business of insurance.

• A financial incentive to subsidize the unregulated, for-profit subsidiary at the expense of the parent company and its policyholders.

The question is whether your departments have sufficient authority and the practical resources necessary to police these inter-company transactions. The tools needed would include financial reporting and analysis, the right of visitation and examination of each component of the holding company...whether that entity is an insurer or not.

B. Fair Compensation of Policyholders

Second, I would raise a concern about asset-stripping. Since all of the assets supporting California Blue Cross' managed care business were transferred to Wellpoint in exchange for common stock, Blue Cross policyholders -- whose premiums funded those assets in the first instance -- have an interest in being fairly compensated.

• This then segues into the question of dividend policy. Should earnings be re-invested in Wellpoint or returned to the stockholders -- including California Blue Cross -- as dividends? As a practical matter, just how do corporate officers who sit on the Boards of both the parent corporation and the subsidiary sort out their fiduciary responsibility to shareholders versus their Blue Cross charter obligation to policyholders? Are the Blue Cross policyholders' interests in reasonable compensation adequately safeguarded?

C. Capital Requirements

Third, I should hope the Committee would think through the implications of transactions like this one for the capital requirements of the parent Blue Cross company.

• While business diversification may add strength to the parent company, history elsewhere in the Blue Cross family suggests that a contrary result may come about as well. As I understand it, the gains and losses of Wellpoint and its subsidiaries will be reflected in California Blue Cross's consolidated financial statement.

• Additionally, California Blue Cross will now include considerable common stock among its assets. In my experience, this is relatively uncommon. Does this pose any particular problem?

Market Concentration

The second area of concern relates to the impact of transactions such as this one on the structure and behavior of insurance markets and insurers, broadly defined. While a restructuring of the private market may be inevitable (and with luck, even salutary), I think this group will agree that it is vital for state regulators to have the tools necessary to intervene to prevent or correct for dysfunctional markets.

As the major insurers and managed care providers position themselves for some version of managed competition--expanding their positions both horizontally and vertically -- the

protection of consumer and public interests becomes increasingly important. I hope, therefore, that your review of the Model Holding Company Act and the other statutes relating to Blue Cross Plans will be animated by the question: will state regulators be in a position to address problems arising out of new, more highly integrated insurance and managed care arrangements, more concentrated markets and less dispersed market power?

Model Holding Company Act

Looking directly at the Model Holding Company Act, I would like to suggest three specific issues for your consideration:

• The first is the question of whether all Blue Plans should be covered by the Act. If so, you will need to amend Section 1, accordingly.

• Second, there is the issue of whether the Act should also apply to managed care organizations, whether they are independents or insurance subsidiaries. If Wellpoint or, downstream, the California Care Plan, an operating HMO subsidiary of Wellpoint, wished to acquire another substantial HMO or merge with a domestic insurer, should the Model Holding Company Act come into play? As I read the Act, the merger between Wellpoint or any of its progeny in the managed care business and a domestic insurer, for instance, would not come under the Act's jurisdiction.

• Third, there is a very important question of competitive injury. Section 3 D of the Act authorizes the Commissioner to disapprove a merger or acquisition of control if he or she finds that the "effect" would be to "substantially lessen competition in insurance ...or tend to create a monopoly therein." An administrative hearing and decision are required within an extraordinarily tight set of deadlines.

As a practical matter, I think this standard and procedure are far too onerous in relation to the public purposes they seek to protect. Monopolization, for example, requires proof of intent, anticompetitive conduct and "a dangerous probability of success." I wonder how many departments have or could realistically think of mounting a full blown, successful antitrust case administratively, particularly under the strictures of the Model Act.

If you agree with the basic premise that now, more than ever, regulators will need to have the tools and resources necessary to police a more complex and concentrated market and a set of competitors with substantial market power, I would hope that this Committee would make a comprehensive study of Section 3D of the Holding Company Act.

By: Larry Kirsch
President, Consumer Health Advocates
Boston, Massachusetts
(617) 720-0162

Mr. HUNTER. They have never had to deal with it, of course, because of the McCarran-Ferguson antitrust exemption.

Chairman STARK. Well, I think it is interesting that there is far more hue and cry for tort limitation. That is their idea of consumer protection, you know, malpractice reform. I mean, that is the sum and substance of it. And we are hearing in all of these ideas that it is—I mean, this is the laissez-faire kind of stuff that makes Ronald Reagan look like a socialist.

There is nothing the market cannot do in this area, and there is precious little evidence that the market has any concern for the beneficiaries. There is none.

I must hasten to say that that is not true of the providers. They are not jumping up and down to get into this HIPC racket. You know, I have got to think that most doctors are in that business because they want to take care of people, and most people are running hospitals because they really do think it provides a humanitarian service. That excludes the for-profits, who are in the business just to rip off as much money as they can. But the nonprofit hospitals, I think, in general, are there to provide a service in their community.

What it appears to me we are doing is creating a whole new entity, which in itself needs to be regulated, which in turn is going to regulate a kind of professional commercial intercourse that works OK; it just works better in some States than others. It boggles my mind, if we are going to get this in place by the end of this decade, what we are going to do. I mean, where do people go to complain? Who does get punished or not punished?

The idea years ago—are any of you attorneys? All of you? None of you.

What is this nonsense of the liability of the enterprise? Is that what I am hearing? Is that the right—you cannot sue the doc; you sue the HIPC?

Now I do not know what they are getting at. I mean, I am suspicious as Billy be damned, but I cannot——

Ms. O'SULLIVAN. I suppose it is to reduce defensive medicine, the doctors' incentives to perform defensive medicine, the idea being that the doctors——

Chairman STARK. You cannot sue me, so I will do whatever I feel like.

Ms. O'SULLIVAN. And you are talking about making things offenses. I think questions should be raised whether or not unnecessary services performed on an individual ought not to be a battery in the——

Chairman STARK. Go ahead, Mr. Hunter.

Mr. HUNTER. The idea, as it was explained to me, was that putting the HMO, let us say, on the line instead of the doctor would put pressure on the HMO to discipline doctors better than the current peer review and make sure doctors are doing the appropriate medicine.

Chairman STARK. That would not be hard to accomplish.

Mr. HUNTER. That is the idea. But it worries me to put caps on malpractice at the very time when we are worried about underutilization and other possible abuses. If doctors hurt people and

cannot get lawyers to protect them, you know, that is another protection taken away, in my view.

Chairman STARK. So I do not know. I am not necessarily opposed to this liability of the enterprise. I am suspicious.

Mr. HUNTER. I want to see it, obviously, but I——

Chairman STARK. But what does it do? Maybe you have got a better target.

Mr. HUNTER. You have a deeper pocket. And a lot of people do not sue their doctors. 90 percent of malpractice does not result in a lawsuit. So maybe he would feel freer to sue an HMO. It might actually drive malpractice costs up.

Chairman STARK. As I say, I use that as an example of a new area. As I say, I am skeptical because of the proponents of the idea, but I cannot, I mean——

Ms. O'SULLIVAN. I think these challenges——

Chairman STARK. It is just like selling these HMOs to the public. It takes me awhile to figure out how I could steal a million dollars doing that, and once I figure out, I figure if I can do it, there is a legion of people out there who can steal even more and not get caught. I would get caught.

Ms. O'SULLIVAN. But these huge regulatory challenges really are going to be there, I think, under any major fundamental reform to the health care system. They are just something that we are going to have to deal with, whether it is a single-payer plan or something else.

Chairman STARK. What would be wrong with saying that the insurance commissioners ought to stick to those areas where it is necessary to actuarially determine reserves, and there is, in fact, an actuarial risk that you can determine?

I mean, a lot of this stuff is pretty much just bill paying, and there is not a lot of determinable risk, particularly if you take away medical underwriting.

The risk is all determined in the marketing, and they basically just eliminate it. To me that is not actuarial science. You have fire insurance on stuff that will not burn. It sounds like a good business.

Mr. KIRSCH. I think you would probably invite some of the most atrocious antisocial practices on the part of insurers that you could ever imagine. I think you would wind up, if you limited the insurance commissioner to determination of, and compliance with, minimum reserve requirements——

Chairman STARK. Well, I am suggesting you have to have somebody else in there to deal then with the medical delivery part of the equation.

Mr. KIRSCH. But also rates, also underwriting.

Chairman STARK. Those, I think, the HIPCs are going to determine, you see. As I understand this, there is a bidding process. They do not have rates anymore. You bid, and then the low bidder establishes the price; it is an auction market actually.

Mr. KIRSCH. I think that is true in some parts of the country, but I think I quite agree with——

Chairman STARK. No, I mean, that's what I think is anticipated in——

Mr. KIRSCH. No, but I quite agree with Mr. Pomeroy. Consider North Dakota or consider Montana. Consider a lot of the sparsely populated——

Chairman STARK. The District of Columbia. I have no bidders.

Mr. KIRSCH. Right.

Chairman STARK. Look at this. You perceive that the market is a bunch of anxious, salivating insurance companies dying to get a hold of these beneficiaries and provide them a service, right, so they are going to be bidding. I mean that is the image that is created, OK.

Therefore if the market works right, if I understand this market business, you will get a good price. Competition will encourage people to bid lower to get all these beneficiaries in their program.

But what is the situation and what are the dynamics of that market if I am responsible, let us say, for the District of Columbia in providing service to 300,000 people, which is about where we are at here, who are either uninsured or Medicaid beneficiaries, and I do not get any bids? Then what do I do?

I go out and—it is a seller's market. I am running around begging somebody to please take my 300,000 people and service them. And if you do not think those prices are going to get very high in a hurry—

I mean if this thing reverses, if everything is fine and there is indeed a buyer's market, and if everybody is breaking down my door, I will tell you that is going to exist in Chevy Chase and a few isolated barrios around the fringe of Washington, D.C., but in Ward 7 or Ward 8, you just are not going to find any takers.

Mr. KIRSCH. The concern that I have is that the kinds of markets visualized by the Jackson Hole group have never existed, and they certainly are not going to exist in the future. They are not going to function as seamlessly, as perfectly, as all of that.

You know, you talked about how people are going to discern quality? How are they going to compare quality from one plan to another?

Chairman STARK. Do you know how many people belong to this club in Jackson Hole or how many legislators are purporting—and how many of the Fortune 500 were in that White House gang?

Ms. O'SULLIVAN. But these questions are——

Chairman STARK. Wait a minute. How many of them do you think belong to HMOs? How many Senators and Congressmen do you think belong to an HMO?

Mr. HUNTER. Nobody.

Chairman STARK. You could not count them on your hand. So what do they know? It is great for everybody else. Even Entovin and Elwood do not belong to HMOs. Let everybody else get in. What a hell of a deal? You know, you guys join first. That is what we are up against. Do you think Garramundi belongs to an HMO? I do not know; I will bet you a nickel he does not.

Ms. O'SULLIVAN. I have no idea.

Mr. KIRSCH. The point I wanted to make, though, is that because this market is not going to function as invisibly and as perfectly as the proponents might think it is, that for precisely those reasons, you have to have effective regulation. Otherwise you are going to have the worst kind of medical underwriting, even with so-

called open enrollment. You are going to have the worst kind of skimming. You are going to have the worst kind of quality degradation. You are going to have people chosing randomly because they are going to have incomplete information.

I do not know that there is any single model for health care reform. I tend to believe that there is no one model that fits all situations. The model that fits North Dakota is not going to be the right one for San Francisco.

But to get rid of the regulatory apparatus simply because we are going to have managed competition strikes me as very, very dangerous.

Chairman STARK. Well, I think there is going to be something like that. But as I say, I share your feelings, and I hope that we can provide some guidelines, at least. The States will not accept willingly—I mean, our fight over supplemental, medigap, forever and ever and ever, and the resistance is basically States' rights. You thought you did away with that in the Civil War, but hope springs eternal, and they do not want to do it.

Well, thank you. I hope that you will keep our feet to the fire as we wind through this, because during the next couple of months, we are going to see some astounding new concepts, and I think precious little concern for the beneficiaries in this area. I appreciate the work you all do in it.

Thank you very much for sharing your thoughts with us today.

[Whereupon, at 2:22 p.m., the hearing was adjourned.]

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STATE HEALTH REFORM INITIATIVES

TUESDAY, JUNE 8, 1993

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:20 a.m., in room B–318, Rayburn House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
TUESDAY, JUNE 1, 1993

PRESS RELEASE #14
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON HEALTH CARE REFORM: STATE HEALTH REFORM INITIATIVES

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on State health reform initiatives. This hearing will be held on Tuesday, June 8, 1993, beginning at 10:00 a.m., in room B-318 Rayburn House Office Building.

In announcing the hearing, Chairman Stark said: "Much has been made of State health reform initiatives that are designed to expand access and control rising health care costs. This hearing will take a careful look at specific policies and programs that have been adopted by several States. Testimony provided at this hearing should help to define the proper role for the States in health care reform."

Oral testimony will be heard from **invited witnesses only**. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND:

Numerous States have developed or are in the process of developing health initiatives to cover the uninsured, reform the private health insurance market, and control the growth in health spending. This hearing will review various State health reform plans, with a more detailed examination of plans developed in six States: Hawaii, Florida, Minnesota, Vermont, Washington, and Maryland.

Hawaii is the only state that has implemented a system to ensure universal coverage. In 1974, Hawaii mandated that all employers provide health insurance, with defined mandatory benefits, for workers spending more than 20 hours per week on the job. In 1990, Hawaii established the State Health Insurance Program, which offers low-cost coverage to individuals who are not covered by the employer mandate and are not eligible for Medicaid.

Florida's legislature enacted a health reform plan in March of 1992. The plan is designed to assure access to basic health care for all Floridians by December 31, 1994. The plan includes small group and other insurance reforms. It also puts in place the infrastructure to develop health purchasing cooperatives that would contract with accountable health plans to provide a mix of privately and publicly funded care.

Minnesota's plan, MinnesotaCare, enacted in April, 1992, expands an existing child health insurance program to offer affordable health care to low-income uninsured persons, and also includes small group and individual insurance reforms. Minnesota adopted a provider tax and higher cigarette taxes to finance expanded health insurance coverage and established an expenditure target to limit the growth in health spending.

(MORE)

-2-

The Vermont plan, enacted in 1992, laid out a framework for restructuring the delivery system, including some of the strongest cost containment provisions of any State. Under the Vermont plan, the Vermont Health Care Authority (VHCA) is required to prepare proposals for both a single-payer and a regulated multi-payer system to present to the legislature in November 1993. The VHCA is also responsible for developing expenditure targets and global budgets. Ultimately, the plan calls for a binding, unified budget by 1994.

The Washington State plan, adopted in April of 1993, would increase coverage through a mandate on employers and individuals and an expansion of an existing state funded program to cover low-income individuals without employer provided health benefits. By 1999, all individuals would be required to enroll in a certified health plan. A minimum benefit package would be defined for certified health plans. To control the growth in health spending, maximum premiums would be established for the minimum package, and the increase in premiums would be limited to the growth in Washington per capita income. Health insurance purchasing cooperatives (HIPCs) would be established. Employers could contract directly with certified health plans or offer employees a choice of plans through the HIPC. Employers with more than 7,000 employees could self-insure.

The Maryland plan, enacted in April of 1993, establishes a new Health Care Access and Cost Commission to formulate the standard benefit package, establish a health care database, foster the development of practice parameters, and implement a payment system. Under the Maryland plan, the payment system will provide a non-binding framework for determining the ultimate price of health care services. The plan also includes small group insurance reforms.

Invited witnesses are asked to respond to the following questions. First, to what extent does the State plan guarantee health insurance coverage to all State residents by a specified date? Second, what specific policies and enforcement mechanisms are used by the State to expand access and coverage? Third, is the plan designed to control the growth in public and private health spending? Fourth, what specific provisions were adopted by the State in order to limit the growth in health spending?

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Tuesday, June 22, 1993, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

* * * * *

Chairman STARK. Good morning. I apologize for the tardiness.

This morning the subcommittee continues its hearings on health care reform with a focus on the State programs.

There has been a great deal of discussion about the many health reform initiatives under consideration by State legislatures. In fact, some would claim that because the States have moved so quickly and with such innovation that Federal intervention could be counterproductive at this time.

With varying degrees of ambition, a number of States are in the process of developing or implementing policy measures to make health insurance more widely available to uninsured and underinsured State residents. A few States have even tried to develop a strategy to control the growth in health care spending.

This hearing will examine the activities underway at the State level. We will review in detail the policies and programs that have been adopted by six States: Hawaii, Florida, Minnesota, Vermont, Washington, and Maryland. We focus on these States because they are generally considered to be leaders in health care reform.

We will ask each of our State witnesses to describe their respective State health reform plans, and I hope that each witness will respond to the following questions on coverage and access to allow the committee to compare:

One, does the State plan assume universal coverage of all or virtually all State residents with an enforceable plan and by a specified date?

Two, what specific policies and programs were enacted by the State legislature to achieve universal access and coverage?

And, three, did the legislature raise the revenues needed to cover the additional cost of providing coverage to low income or uninsured residents?

On the issue of cost containment, I would ask each witness to answer the following questions: Does the State plan include an enforceable cost containment mechanism to control the overall growth in health spending in that State? And, two, what specific programs and policies were adopted by the State to control total health care spending?

No doubt, the role of the States will be among the critical questions considered within the context of national health reform. Many health care reform proposals would allow a major role for the States in health care reform—although the degree of Federal oversight in such proposals varies from proposal to proposal. In my view, Federal oversight is critical to the successful implementation of a national health care reform plan.

Testimony provided today should help to define the proper role for the States in health care planning and reform.

Before proceeding, I would like to acknowledge the ranking member of the subcommittee, Mr. Thomas, for any statement he would care to add.

Mr. THOMAS. Thank you, Mr. Chairman. I, too, apologize for being late. We were both at another meeting.

I think all of the questions that the Chairman asks the witnesses to answer are useful. I don't believe, however, they are primary.

It seems to me that the movement at the State level is in response to some of the same concerns that we at the Federal level

are focusing on. The problem is, of course, that the States are States within a Federal system and that the Constitution, quite rightly, apportions certain powers to the central government and leaves certain other powers to the State governments.

And it seems to me if we were both grappling with the same problem—and, after all, citizens of a State are also citizens of the Nation, and the dual citizenship has caused us some concern over the years. It is, in fact, also a question of the allocation of powers within that Federal system.

And the primary question I would like answered by each of the witnesses was that—did you find that you had available to you all of the options that you wished to take and took those which you preferred over others? Or, in fact, were you limited by the Federal system? And that were we at the Federal level to effect changes in laws or provide enabling legislation in the area of antitrust, insurance, tort reform, malpractice or other areas, you might have better been able to meet the needs as you saw them in terms of serving your citizens, who are, after all, also our citizens?

So, Mr. Chairman, I look forward to testimony and would ask that the question of the Federal system and the difficulty the States have had in operating under it in terms of answering the need of the health care would be a question that I would also like to ask.

Thank the Chairman.

Chairman STARK. Are there any other statements?

The Chair had hoped to have a chart, but, high technology being what it is in the House, the best I can offer you is a piece of paper which I am asking the staff to distribute to witnesses and the Members alike and—insofar as there are any left—to the audience.

It is a comparison that I asked the staff to make of the six States' programs dealing with the questions that I outlined in my opening statement that might help us as we go down during the discussion with witnesses to get some idea of at least how the staff interpreted what their reform initiatives include and do not include.

I can vouch for it as an honest attempt to interpret the State plans as best I can, but I cannot vouch for its absolute accuracy.

[The chart follows:]

COMPARISON OF SIX STATE HEALTH REFORM INITIATIVES

STATE	COVERAGE AND ACCESS				COST CONTAINMENT	
	Plan assumes goal of universal coverage	State enacted specific policies to guarantee universal access and coverage	Other initiatives enacted by State to expand access and coverage	State plan raises revenues to cover the additional cost of covering the uninsured	State plan includes enforceable cost containment mechanism	Other state initiatives to control health spending
Hawaii	yes	yes employer mandate; subsidized insurance program (SHIP); Medicaid expansion	insurance reforms	yes	no	managed care initiatives; malpactice reform
Florida	yes	no	Medicaid buy-in; purchasing cooperatives; insurance reforms	no	no	purchasing alliances; expenditure data; practice parameters; malpractice reform; certificate of need
Minnesota	yes	no	expanded public program; insurance reforms; tax deduction for self-employed	yes	no, but plan includes voluntary statewide and regional spending targets	integrated service networks; review of capital exenditures; mandatory Medicare assignment; malpractice reform
Vermont	yes	no	expanded public program; insurance reforms	no	yes: enforceable unified budget	malpractice reform, practice guidelines; admin. simplification; certificate of need
Washington	yes	yes: employers & individual mandate; purchasing cooperatives; expansion of state funded plan; Medicaid expansion	insurance reforms	yes	yes: limits on premiums	malpractice reform; practice guidelines, admin. simplification; certificate of need
Maryland	no	no	insurance reforms	no	yes, but applies only to hospital payments	establishes physician payment system; data collection; malpractice reform; admin. simplification; certificate of need

Mr. THOMAS. I assume by this chart, Mr. Chairman, this is not to assume that the six State health reform initiatives on the chart are considered the most comprehensive or necessarily the best?

For example, California, New York, Oregon and a number of other States that I have not mentioned have carried on significant reform. So what is the rationale for the six in front of us to be singled out and elevated to this level versus the other States?

Chairman STARK. We felt these are a selection of those that had good programs and had the legislation passed. As the gentleman knows, the California plan is relatively new and really not in operation, and it may or may not be an excellent one. We are trying to get a representative——

Mr. THOMAS. For the record, I would like to say the California one will be, I am sure, an excellent one. You can speak for yourself. I am going back home next weekend. I don't know where you are going.

Chairman STARK. So that these were just a group of States selected because they seemed to have had plans earlier and more comprehensive plans than the average.

Mr. THOMAS. And when we talk about them, if the staff or others would kind of group other States with those that seem to be somewhat similar or have features that are similar so that we can tend to be fairly comprehensive in mentioning all of those States who have made reforms, that would also be helpful.

Thank the Chairman.

Chairman STARK. I think the witnesses will be able to comment on that as well.

Our first witness is Dr. David Helms, who is president of the Alpha Center, and he will be testifying on the broad issue of State involvement in the health reform area.

Welcome to the committee, Dr. Helms, and why don't you proceed to enlighten us.

As with all the witnesses today, their prepared testimonies will appear in the record in their entirety. We will run a clock to set a time schedule. And I know the Members will want to question all of the witnesses, and that will lead us to broadening out the information or expanding on the information that is given in your testimony.

Why don't you proceed in any manner you are comfortable, Doctor?

STATEMENT OF W. DAVID HELMS, PH.D., PRESIDENT, ALPHA CENTER, WASHINGTON, D.C.

Mr. HELMS. Thank you, Mr. Chairman, for the opportunity to testify on State capacity to achieve health care reform.

The States represented on the panel today are leaders in State reform. They provide important lessons about the types of reform which are politically viable in different parts of the country. They also provide insight in how States are combining different reform approaches such as managed competition, employer mandates and global budgets. Even more important, I think, they provide useful lessons on key implementation issues.

While I want to emphasize the important progress that States are making, I very much need to stress that States need and I be-

lieve would welcome Federal support and guidance. Clearly, States are unable to achieve comprehensive health reform entirely on their own. This is a Federal system. Without Federal leadership a few will act to the degree they can. For the rest, the capacity to implement reform is highly variable. The Federal Government can improve State capacity and expedite the transition to a reformed system through clear guidance, funds to develop needed operational capacity and technical assistance.

So why are States pursuing health care reform? You know only too well about the rate of cost increases, especially for Medicaid, and this is no longer sustainable for many States. Of course, the increasing numbers of the uninsured, I think, coupled with the recognition of a fundamental breakdown in the small employer market, and probably most important I believe is a recognition that the incremental changes which the States have tried—and about which we have testified before this committee—including subsidy programs and market reforms, will not achieve the generally accepted goal of insuring universal access. Lastly, the States believe that significant savings can only be achieved by fundamental reform of the financing and delivery system. Also, I think, frankly, there is some uncertainty about whether and when the Federal Government will act.

So where are the States in the reform process today? It is always difficult to classify States, but I am going to take this one on for you, Mr. Chairman.

There are eight States which have already passed significant comprehensive health care reform legislation and are at various stages of implementing it, and some have hit roadblocks. The eight States which have passed reform care are Hawaii, Minnesota, Vermont, Oregon, Washington, Florida, Maryland, and Massachusetts. In my testimony I have highlighted the major elements of their reform and also provided you an exhibit which describes the key elements of those reform strategies.

In addition to these eight States, four States are undertaking major demonstrations which would build capacity for more comprehensive health care reform, including California, New Jersey, New York and Iowa. An additional 22 States have commissions and task forces which are studying this issue. And virtually all the States have been active in reforming their health insurance market.

Thus, most of these States are actively reforming the insurance market and studying these fundamental reforms, and we have eight States which are making substantial progress in health care reform.

What reform strategies are being pursued by these leading States? They are looking for major strategies to increase financial access, which include examining new tax finance systems, mandating both on employers and individuals, and providing subsidies for the uninsured.

Congressman McDermott remembers the Washington State Basic Health Plan, which he helped to fashion when he was a leader in that State's legislature, as an example of a State subsidy program for individuals below 200 percent of poverty. States are looking at expenditure caps and targets as a key strategy for controlling costs.

They are trying to do all-payer rate setting systems, not just for the hospitals but for other sectors including ambulatory and physician services.

They are all interested in the concept of managed competition. They want to reorganize the delivery system. They are looking at establishing purchasing cooperatives and trying to achieve greater administrative efficiencies. Through their reform efforts New York is a leader in trying to develop an electronics claims platform system.

The major strategies for improving the health care delivery system, include developing more integrated service networks which link vertically hospitals and managed care plans. They are also working to improve access for underserved populations, and building and expanding primary care.

I am frequently asked whether the Federal Government should foster further State experimentation in health care reform? The arguments made against it are the States lack the financial resources. And, as you will hear from the States testifying today, this is a serious problem. States will require exemption from the ERISA statute and waivers under Medicaid and Medicare.

State reforms, especially those that impose mandates on employers, could adversely affect a State's economy. States like Oregon and Washington, as they have tried to move their strategies through, have heard the argument that large multi-State firms would face higher administrative costs if they had to operate in many different State systems. It is argued, you run the risk of dissipating the momentum for national health care reform by allowing States to implement their own reforms. And once a national plan is passed it might be difficult to bring those States which have moved ahead back into the Federal framework.

I think the arguments made in favor of State experimentation are more compelling. They include that State health care reform strategies are more tailored to their local conditions. It is easy to build public support for a specific State plan. It builds experience in the States, which we will ultimately need to operate and administer reform. It allows States to serve as laboratories that will help inform the national Government about what works and what does not. And, frankly, while we are waiting for the national Government to decide, the States can at least begin to improve access and control costs.

So what then are the appropriate roles for the Federal Government and for States under a national reform plan? Well, the important roles for the Federal Government include mandating participation by all parties in the system, including employers and individuals.

In our work with the Robert Wood Johnson Foundation on the health care for the uninsured program, we learned that significant subsidies, up to 40 percent of the premiums for employers, will not enable us to achieve universal access to insurance through voluntary means. We need to mandate participation.

We need to establish a standard uniform financing system. While a few States have been able to pass legislation specifically as to how universal access will be financed, this aspect of health care reform remains beyond the political means of most States.

We need to establish a standard uniform benefits package, and, most important, the Federal Government needs to set clear and consistent national policies for key aspects of operating a reformed national system. And I have outlined a number of areas where those standards and policies would be useful.

States, under national health care reform, should build upon their traditional roles. Under the national reform plans under consideration they would do important things such as reorganizing that market, overseeing the development and operation of integrated health delivery networks, administer subsidy plans and conduct a resource allocation process.

Under a national reform plan, States should be given flexibility. I think States are ready to accept Federal direction within a system of shared responsibilities. In general, the States believe they should be held accountable for the goals of access and cost containment rather than specific processes used.

States are concerned about the extent of their financial obligation to assure access and their accountability for meeting expenditure targets, but many appear ready to accept the responsibilities if given the flexibility and resources.

So how can you at the Federal Government expedite a transition to a new system? Provide State reform development grants, provide technical assistance, and foster further State experimentation now.

Once national health care reform is passed, States will continue to need funding as well as technical assistance for further development of their infrastructures.

Mr. CARDIN [presiding]. Dr. Helms, thank you for your testimony.

[The prepared statement and attachment follow:]

TESTIMONY BEFORE THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES

W. David Helms, Ph.D.
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June 8, 1993

STATE CAPACITY TO ACHIEVE HEALTH CARE REFORM

Mr. Chairman, thank you for the opportunity to testify today on state capacity to achieve health care reform. My name is David Helms, and I am President and founder of the Alpha Center, a non-profit organization with an 18-year history of providing technical assistance to states and the federal government in health care policy. The Alpha Center began as a Center for Health Planning, providing technical assistance to northeastern states for that program. Among other activities, we now serve as a contractor for the Agency for Health Care Policy and Research (AHCPR) conducting workshops for state and local public officials. We also serve as the national program office for three initiatives of The Robert Wood Johnson Foundation, including its State Initiatives in Health Care Financing Reform program, a program funding the development and implementation of health care reform in 12 states which will soon be expanded to assist more states.

The states represented on the panel today are leaders in state health care reform. They provide important lessons about the types of reform which are politically viable in regions of the country. They also provide key insights into how states are combining different reform approaches such as "employer mandates," "managed competition" and "global budgets." Even more important, they will provide useful lessons on key implementation issues such as structuring purchasing cooperatives and administering expenditure targets and caps.

While I want to emphasize the important progress states are making, I also want to emphasize that states need (and I believe would welcome) federal support and guidance. Once the Clinton proposal is formally introduced and is debated along with Congressional alternatives, states are likely to fall into three categories: 1) those states which will wait for actual legislation to be enacted and then do what is required, 2) those states which will try to anticipate what their roles will be based on the reforms being considered nationally and take steps to get a head start on implementation, and 3) those states which believe they have a better alternative and hope to develop it to the point of being grandfathered in. States in both of the latter categories are likely to have the greatest capacity to implement national reform.

Once passed, however, some states will move faster than others to begin the operation of a reformed health care system with their speed far more dependent on the incentives provided in federal legislation than on any current indicators of state readiness or capacity. I was reminded recently about how quickly the former East Germany adopted the West German system. They were given 90 days by law and in 90 days, the new system was in place. Few in this country would recommend a 90-day transition. Nevertheless, there are steps that can and should be taken to expedite the efforts already underway to develop the infrastructure for a new system.

In this testimony, I review briefly where states are today in the reform process and the reasons underlying their efforts. After pointing out the issues for Congress raised by state experimentation with health care reform, I discuss the roles and responsibilities for federal and state government under a national reformed system. Finally, I consider what states will need now in order to move forward with reform. Clearly, states are unable to achieve comprehensive health care reform entirely on their own. Without federal leadership, a few will act to the degree they can. For the rest, the capacity to implement reform is highly variable. The federal government can improve state capacity and expedite the transition to a reformed system through clear guidance, funds to develop needed operational capacity and technical assistance.

1. **Why have states been pursuing health care reform?**

   A. The rate of cost increases, especially for Medicaid, is no longer sustainable

   B. The increasing number of uninsured coupled with a recognition of a more fundamental breakdown in the small employer market

   C. The recognition that incremental changes which states have tried (e.g., market reforms, subsidy programs) will not achieve their generally accepted goal of assuring universal access

   D. Belief that significant savings can be achieved through more fundamental reform of the financing and delivery systems

   E. Uncertainty about the likelihood of action at the federal level in the near term

2. **Where are the states in the reform process today?**

   A. Eight states have passed significant comprehensive health care reform legislation and are at various stages of implementing reform.

Hawaii:	employer mandate; subsidized insurance product
Minnesota:	integrated service networks; subsidized insurance product; targets for limits on growth in health expenditures
Vermont:	targets for global expenditure limits; universal access through either single payer or mandated multi-payer system
Oregon:	coverage of highest priority services under Medicaid; high risk pool; play-or-pay mandate
Washington:	employer and individual mandate; purchasing cooperatives; expenditure limits; subsidized insurance product
Florida:	purchasing cooperatives; Medicaid buy-in; small group market reform
Maryland:	small group market reform; limits on physician fees; administrative reform
Massachusetts:	play-or-pay mandate; subsidized insurance product

   B. In addition to the 8 states listed above which are implementing various aspects of their legislated reforms, 4 states are undertaking major demonstrations to build capacity for more comprehensive health care reform.

California:	statewide health insurance purchasing cooperative for small employers
New Jersey:	subsidized insurance product
New York:	electronic claims clearinghouse, global budgeting
Iowa:	health insurance purchasing cooperatives and organized delivery system pilots

   C. In addition, 22 states have established commissions or task forces to develop recommendations on health care reform. While these states are certainly far less ready than those above to enact reform, the presence of a commission or task force indicates at least a political discussion has begun in a state. In addition, some of these states (e.g., Colorado, Montana) have very active study bills putting them in a position to implement reform quickly should the state pass reform legislation.

D. Virtually, all of the states listed above have included aspects of health insurance market reform among their activities. The Health Insurance Association of America has recently reported that "26 states have forced insurers to issue policies to anyone who applies, regardless of their health. Thirty-four states have forced insurers to guarantee the renewal of policies. Forty states have placed tighter restrictions on insurance rates."[1]

Thus, most of the states are actively reforming the insurance market and studying more fundamental reforms, with the eight states having passed comprehensive reform legislation being the leaders. See Exhibit 1 to this testimony for more detailed descriptions of the reform efforts being undertaken by these eight states.

3. What reform strategies are being pursued by leading states?

States are currently at various stages of implementing many of the reform components being discussed at the federal level. These state efforts can be categorized as follows:

A. Major strategies to increase financial access

1. Developing new tax-financed systems
   - Payroll tax on employers and employees
   - Income tax
   - Provider taxes
   - "Sin" taxes

2. Mandates
   - Employer mandates
   - Individual mandates
   - Individual and family health accounts

3. Subsidies for the uninsured
   - Subsidized public insurance program for uninsured
   - Medicaid buy-in

4. Restructuring the insurance market
   - Purchasing cooperatives
   - Standard or minimum benefit packages
   - Small group insurance reforms (i.e. community rating to limit rate differentials, guaranteed issue requirements, limitations on pre-existing condition exclusion periods)

B. Strategies for controlling costs

1. Expenditure targets and caps
   - Targets for rate of increase
   - Total budget for health care services for state residents

2. All-payer rate setting
   - Hospital & nursing home rate systems
   - Uniform payment systems for ambulatory care and physician services

3. Managed competition
   - Development of purchasing cooperatives
   - Selection by individuals within groups of approved health plans

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[1]Health Insurance Association of America, as reported in Wall Street Journal, June 2, 1993.

4. Administrative efficiencies
    - Electronic billing and claims processing
    - Electronic coordination of benefits
    - Electronic remittance

C. Strategies for improving health delivery systems

1. Development of integrated service networks
    - Promotion of new managed care plans which link hospital and ambulatory services
    - Promotion of networks in underserved urban and rural areas

2. Improvements in access to services for underserved populations
    - Building and expanding primary care
    - Training primary care health professionals to work with underserved communities

4. Should the federal government foster further state experimentation with health care reform?

A. The arguments usually made against promoting extensive state experimentation are:

- States lack the financial resources to cover all of the uninsured without help from the federal government.

- State reforms would require exemption from the federal ERISA statute and waivers under the Medicaid and Medicare programs.

- State reforms, especially those imposing mandates on employers, could adversely affect a state's economy if firms move to other states.

- Large multistate firms would face higher administrative costs with different state systems.

- Allowing states to implement their own reforms runs the risk of dissipating momentum from national health care reform; and once a national plan has passed, it might be difficult to bring those states which moved ahead in a different direction back into the new federal framework.

B. The arguments made in favor of state experimentation include:

- State-specific health care reform strategies are more tailored to local conditions than a national plan.

- It may be easier to build public support for a state-specific reform plan, given its focus on solving local problems.

- State reforms build experience in operationalizing and administering important aspects of reform, such as subsidizing low-income individuals or restructuring the local insurance market.

- Permitting state reforms allows states to serve as laboratories for key reform options heretofore outlined only in policy proposals.

- State experimentation allows states to move now toward access improvements and cost containment while the country awaits major national reform.

5. **What are the appropriate roles for the federal government and for states under a national reform plan?**

Under a reformed health care system, both levels of government are likely to have key responsibilities appropriate to their roles in a federal system.

A. Suggested roles for the federal government:

- *Mandate participation by all parties in the system, including employers and individuals.* Our work with The Robert Wood Johnson Foundation projects taught that despite significant subsidies of up to 40 percent of the premium for employers, we will be unable to achieve universal access to insurance through voluntary means.

- *Establish a standard uniform financing system.* While a few states have been able to pass legislation specifying how universal access will be financed, this aspect of health reform remains beyond the political means of most states. A federally-specified uniform financing system could reasonably require states to maintain their prior levels of financial contributions. Given their fiscal crises, however, it is unrealistic to expect much of an increase in those levels.

- *Establish a standard uniform benefit package.* A national standard benefit would assure greater equity across states, facilitate coverage by plans covering areas which cross state boundaries, and facilitate coverage by national firms operating in multiple states.

- *Set clear and consistent national policies for key aspects of operating a reformed health care system.* National rules and guidelines should include:

  1) Parameters for insurance market rules (such as factors which may be used in rating premiums or adjusting for differences in risk)

  2) Minimum firm size eligibility for participation in pooled purchasing

  3) Targets for national and state-specific expenditure limits

  4) Specifications for data to be collected for operating the system, assessing its impact, and making policy improvements

  5) Research on health outcomes, technology assessment, and development of practice guidelines

  6) Quality and access standards

  7) Health personnel distribution goals

B. State roles under national health care reform should build upon states' traditional roles in the health care system, including: 1) developing health personnel training programs; 2) regulating provider quality; 3) controlling the supply of health care resources; and 4) serving as a provider of last resort for those who remain uninsured.

C. Under many of the national health reform plans under consideration, we envision states playing a major role in the following:

- *Establish and oversee purchasing cooperatives.* States will need to establish the rules and regulations for how these entities operate, including:

  1) the number of purchasing cooperatives and the geographic areas they serve

  2) governance, including composition and procedures

  3) data collection and submission

  4) methods of adjustment for adverse risk selection

  5) the extent to which they may limit the number of qualified plans offered

- *Oversee the development and operation of integrated health networks/plans.* States will need to specify the criteria and standards for qualified networks, monitor adherence to national quality and access standards, assure access to providers in underserved areas, foster the development of networks in selected underserved urban and rural areas, and ensure coordination of certain services with state and local public health systems.

- *Administer eligibility for subsidized insurance.* States will need to determine the need for subsidies for unemployed individuals and low income workers.

- *Conduct a resource allocation process within a system of national expenditure limits.* States will need to play a major role in a number of related areas, including:

  1) Develop a baseline on state expenditures and collect data to understand future expenditures

  2) Establish a process to enforce nationally-set expenditure limits

  3) Implement transitional price controls, if any

  4) Conduct rate-setting or negotiation on unit prices, hospital budgets, and/or capitated premiums

  5) Establish supply controls for specialized services and high technology

  6) Promote and enforce health personnel distribution policies

6. Under a national reform plan, should states be given the flexibility to implement different reforms? How much flexibility do states want? Why do some want flexibility and others don't?

States are ready to accept federal direction within a system of shared responsibilities. In general, states believe they should be held accountable for mutually agreed-upon goals regarding access and cost containment, rather than the specific processes used to achieve these goals. This argues for some flexibility and the time and resources states will need to build their capacity to perform these expanded roles. States are concerned about the extent of their financial obligation to assure access and their accountability for meeting expenditure targets, but many appear ready to accept these responsibilities if given sufficient resources and flexibility to carry it out.

7. **What can be done to expedite the transition to a new system?**

As noted above, at least 12 states have already taken concrete steps to develop the infrastructure for a reformed health care system. They are likely to be joined by other states which are also actively considering proposals. Despite this significant progress, I believe that about half of the states will be unable or unwilling to take serious steps until a new national system is put in place. However, the federal government can expedite the transition by the following incentives:

A. Provide state reform development grants.

B. Provide technical assistance on the entire range of tasks that states will need to perform.

C. Foster further state experimentation now, prior to the implementation of a new system. Such experimentation will not only build states' capacities but it will serve to provide models offering lessons for national reform or reform in other states. As you no doubt understand well, states will need exemptions from ERISA, Medicaid waivers, flexibility on inclusion of Medicare and other federal programs within the purchasing cooperative (especially for rural areas), and protection from anti-trust laws in order to move forward with such experiments.

Once national reform legislation is passed, states will continue to need funding as well as technical assistance for further development of their infrastructures. However, perhaps most important, they will need clear guidance in the areas specified above. The clearer the guidance and the stronger the federal incentives to implement the system, the faster it can be put in place.

EXHIBIT 1

FOR

**TESTIMONY BEFORE THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES**

STATE CAPACITY TO ACHIEVE HEALTH CARE REFORM

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FLORIDA

Florida's Health Care Reform Act of 1992 called for voluntary approaches to reach universal access and achieve cost containment goals by December 1994. The act simultaneously established the Agency for Health Care Administration (AHCA) which subsumed various agencies and employees in order to focus the efforts of financing and regulating the health care system into one agency. In addition, the AHCA was charged with submitting a back-up to the legislature plan, such as a play-or-pay employer mandate in case the voluntary efforts failed. A year later, Florida passed the Health Care and Insurance Reform Act of 1993, essentially calling for a reorganization of the health care delivery system.

With the provisions of these two laws, Florida has put into place the structures needed in order to organize the health care system using a **managed competition model**. **Community Health Purchasing Alliances** (CHPAs) have been designated to coordinate both the purchase and delivery of health care in 11 exclusive regions around the state. These alliances will be nonprofit and will serve a voluntary membership of small businesses (1-50 employees), state employees, and Medicaid and Medicaid Buy-In enrollees. CHPAs covering non-urban populations would be allowed to merge. The roles of the CHPAs would be to (1) regulate alliance membership and the benefits offered by the accountable health plans (AHPs), and (2) disseminate information on AHPs to members and employees of members that can then be used to compare health plans. CHPAs would not be risk-assuming entities.

Florida has also enacted **reform of the small group market**. Typical of this type of reform, Florida requires all insurers to provide "**guaranteed issue**" coverage to small employers, their employees, and any dependents. Medical underwriting and pre-existing condition limitations are prohibited, although benefits provided in riders above and beyond the standard package may be medically underwritten. **Modified community rating** would be required.

Further, Florida is developing a **Medicaid Buy-In Program** (MBI) which is dependent upon a waiver from HHS. The MBI would be open to all persons in the state with incomes below 250% of the federal poverty level who have had no private health insurance in the past year.

Other reforms being undertaken in Florida are the continuation of efforts to reform the rural health care system, the development of practice guidelines, and a study of fraud and abuse.

HAWAII

In 1974 Hawaii passed the **Prepaid Health Care Act (PHCA)** requiring employers to provide health insurance coverage to employees who work more than 19 hours per week. Under the PHCA, employers must pay at least 50% of the premium for these employees; employees can be required to pay up to 50% of the premium, but not more than 1.5% of their monthly wages.

Historically, Hawaii has maintained a **very generous Medicaid benefit** insuring medically and categorically needy individuals, elderly and disabled individuals with incomes up to 100% of poverty, and children under age 6 with family incomes up to 133% of poverty. In addition, expectant mothers and infants are entitled to benefits if their family incomes do not exceed 185% of poverty.

The PHCA and the generous Medicaid benefit, along with Hawaii's historically low health care spending, made it feasible for Hawaii to develop a public financing mechanism, the **State Health Insurance Program (SHIP)**, for the "gap group" -- those not insured through their employer, eligible for Medicaid, or able to purchase private insurance. SHIP is a subsidized health insurance program for the uninsured who are below 300% of poverty. The subsidies are based on income and family size and the benefit package provides strong incentives for outpatient care -- only five hospitals days are covered. SHIP has made several efforts to reduce the barriers to care, including shortening its application forms, developing a broad-based community outreach program, working closely with its public agency partners, and using the media.

Over the past few years, Hawaii has seen its health care costs increase markedly. As a result, in 1990 the state legislature created a Blue Ribbon Panel to propose steps for controlling rising health care costs. In an attempt to address this concern, the state is considering the implementation in January 1994 of **Quest**, a system of managed competition for publicly funded coverage. The proposed program is intended to enhance the quality of care while providing universal access, develop efficient utilization of services while controlling costs, and transform public assistance health care into a more privatized mode while promoting effectiveness and efficiency through managed care.

MARYLAND

Historically, Maryland has favored regulation of its health care system. In the 1976, Maryland established an all-payer hospital rate setting system which still exists today. In addition, Maryland has mandated many health benefits and it continues to operate its certificate of need program.

In April 1993, Maryland passed legislation which mandates further reform of the health care system through a regulatory approach. There are two major goals of the legislation: 1) increasing access to health care through insurance reform, and 2) containing health care costs. The legislation includes the following provisions:

- **New Commission:** The legislation establishes the Maryland Health Care Access and Cost Commission as of July 1, 1993. The commission will gather and publish data on prices and practices, including the fees of individual doctors, and control rates for certain health insurance premiums and medical services.

- **Small Group Health Insurance Reform:** By July 1, 1994 carriers **must offer a comprehensive standard benefit plan** (to be determined by the Commission) to all employers with 2-50 employees who work a minimum of 30 hours per week. All small groups within a carrier are to be **community rated** with adjustments for age and geography only. The geographic adjustment is limited to four specified areas of the state, and the allowable difference in community rates will be reduced from 50% to 16% over four years, with the Insurance Commissioner required to report on the feasibility of a pure community rate by October 1, 1998. In addition, **pre-existing conditions exclusions are to be phased out** by January 1, 1995, but until then they may be applied for only 6 months and must be based on only a 6 month history. The carrier may charge up to 1.5 times as much for deductibles and cost sharing if the person was not previously covered.

- **Practitioners' Fees:** By January 1, 1995, the commission must develop and implement a payment system for all health care practitioners in the state. The reimbursement must include a factor representing resources, a factor representing the relative value of health care services, and a conversion modifier which is the payer's standard, the practitioner's standard, or an arrangement agreed upon by the payer, the physician, and/or the practitioner. The practitioners may set their baseline charges, but if voluntary efforts to control fees are unsuccessful, the Commission can restrict the rates.

Other portions of the legislation address the development and analysis of practice parameters, guaranteed open enrollment in an individual's choice of benefit plan once he or she has been a resident of Maryland for at least 60 days if 60% of Maryland's under-65 population is insured, and the reporting of professional liability claim judgements, settlements, and final dispositions.

MASSACHUSETTS

In April 1988 Massachusetts passed comprehensive legislation, the Health Security Act, which provided for the establishment of a **statewide "play-or-pay" system** to be implemented by January 1992. This provision of the legislation requires that companies with six or more workers either offer health insurance or make a per-employee contribution to a state pool which would finance minimum basic health insurance policies for uninsured workers. Due to changes in the political environment (a new Governor) and in the economic environment (a major recession in the state), the state legislature voted to delay the implementation of the "play-or-pay" employer mandate until 1995.

While the implementation of this major component of the legislation has been delayed, several components of the legislation have been implemented. Disabled children, disabled working adults, and individuals leaving welfare to go to work have been able to obtained health insurance through the Department of Medical Security since 1990, and the number of enrollees continues to increase. Unemployed workers receiving unemployment insurance and individuals not previously insured are also eligible to purchase insurance through the Department of Medical Security. In addition, college students are now required to have health insurance coverage.

MINNESOTA

In April 1992 Minnesota passed the **HealthRight Act of 1992**. The law's primary goals are to provide **expanded access to affordable health care for all Minnesotans** and to **reduce the rate of growth in health care spending**. It lays out an incremental, comprehensive approach to increasing access to care. The MinnesotaCare health plan builds on a former state program for uninsured children by adding their parents and other low income adults. The law also contains significant cost containment provisions and newly devised public processes for setting overall health care spending targets, monitoring providers, reviewing the distribution of new health care technologies, and evaluating methods for collecting health care data. A 25-member Health Care Commission was established which developed a plan for setting financial targets to reduce the rate of growth in health care spending by at least 10% per year for the next five years.

Another major component of the state's reform effort targets the small-employer health insurance market. The 1992 legislation eliminates or restricts certain underwriting practices and authorizes the creation of a statewide reinsurance pool and a health insurance buying cooperative for small firms.

In January 1993, the Health Care Commission submitted additional legislation, which includes its cost containment plan. In May 1993 the MinnesotaCare Act was passed. This legislation authorizes the formation of **integrated service networks (ISN)** beginning in July 1994 and mandates an **all-payer system for services not covered by an ISN** to be phased-in over a two year period beginning July 1, 1994. In addition, this legislation establishes the **annual limits on growth in health care expenditures** as follows:

1994: CPI + 6.5%
1995: CPI + 5.3%
1996: CPI + 4.3%
1997: CPI + 3.4%
1998: CPI + 2.6%

Health insurance companies, HMOs, and other health plans will be required to keep their expenditures and revenues within these limits for 1994 and 1995. Providers will be required to keep their revenues or fees within these limits for 1994 and 1995. ISNs will be required to hold the annual growth in their total costs to the limits, and non-ISN services will be controlled through the regulated all-payer system.

Other aspects of the legislation deal with the establishment of an information clearinghouse to compile and disseminate information on health care costs and quality, the development of methods of allocating and assessing the costs of medical education and research, the establishment of specific public health goals, technology assessment, and the role of the Health Care Commission.

OREGON

The Oregon Health Plan, as legislated in 1989, encompasses Medicaid expansion, incentives and mandates for employment-based insurance coverage, insurance market reform, and health coverage for persons currently considered uninsurable. Oregon plans to rely heavily on managed care to deliver cost-effective health care services.

A single basic benefits package will be made available to the expanded pool of Medicaid beneficiaries as well as those covered through their employers. A more well-known aspect of the Oregon Health Plan, the **prioritized list of health care services** was developed with the input of consumers, providers, and the judgement of the members of the original Health Services Commission. An ongoing Health Services Commission will be charged with modifying and updating the prioritized list while the legislature will allot the Medicaid budget which will used to determine how many of the services on the list can be included in the benefits package. On March 19, 1993, HHS approved the benefits package as it now stands. Any changes in the prioritization or the cut-off point would require further HHS approval. Questions regarding the impact of the Americans with Disabilities Act (ADA) on the Oregon's prioritized list (as well as any other state's benefits package) are still not reconciled.

In order to increase the number of those covered by **employment-based health insurance**, Oregon has legislated insurance market reforms, focused on the use of the **state's high-risk pool**, and has slated a **play-or-pay mandate to go into effect in 1995** if the voluntary enrollment goal of 150,000 has not been met by then.

Oregon has also: (1) charged a Health Resources Commission with looking into ways to increase the efficiency of the use of technologies, services, and facilities, and (2) begun to investigate increasing health insurance coverage by coordinating worker's compensation insurance with health insurance (e.g., 24-hour coverage).

VERMONT

Vermont's newly established Health Care Authority is currently charged with developing two proposals -- a Canadian-style single payer system and a multi-payer plan requiring all insurers to offer a uniform benefit package. The Health Care Authority consolidates the staff and resources of the state's health planning agency, its hospital budget and health data organization, and its certificate of need (CON) program into a single, coordinated agency responsible for overseeing reforms and shaping a more integrated health care system.

Each of the two proposals must provide **universal access to health care**, utilize **global budgets** for all health care expenditures, and have an overall statewide plan for the allocation of health care resources. The Health Care Authority's analyses of the two proposals is scheduled to be presented to the Vermont legislature in November 1993, where one of the proposals is expected to be approved. Under either proposal, **global budgets** will be combined with binding hospital budget reviews, the CON program, and compliance with the state's plan for the distribution of health care resources. **Non-binding expenditure targets must be developed by July 1993, and a unified health care budget must be in place by July 1994.**

In addition, Vermont will develop a **unified health care database** incorporating data on health care expenditures and the utilization of services. This database will assist the Authority in determining the capacity and distribution of resources, identifying unmet needs, comparing costs, and providing information to consumers and purchasers.

To improve health insurance market performance, Vermont is developing a health insurance purchasing pool for those covered by state government, state colleges, the University of Vermont, municipalities, school districts, and portions of the Medicaid case load. Vermont is also considering a uniform claims form, uniform utilization review procedures, and recommendations to include long-term care services in whichever universal access plan is chosen.

WASHINGTON

The Washington Health Care Commission worked for approximately two years to develop recommendations for health care reform. Based in large part on its recommendations, the state recently enacted the Washington Health Services Act of 1993, becoming one of the first states to pass comprehensive reform.

The following are key elements in the legislative package.

- **Washington Health Services Commission**: The Commission established by the legislation will consist of five full-time members charged with creating a **uniform benefits package**. They will establish a maximum **community-rated premium** annually, subject to the statutory requirement to "ratchet down" the premium until the annual increase is no more than the five-year average rate of personal income growth. The Commission will determine the need for risk-adjustment mechanisms for certified health plans; monitor growth in health services costs; monitor the application of technology; evaluate and approve major capital expenditures; and establish reporting requirements for certified health plans. In addition, the Commission will establish the financial participation levels of enrollees (based on income) and propose voluntary guidelines for certified health plans regarding risk- and utilization management, the use of technology, and methods of payment.

- **Employer Mandate**: The employer mandate requires that employers pay at least 50 percent of the cost of the uniform benefit package for each employee and his or her dependents. Pro-rated contributions for part-time workers and their dependents are also required. The legislation also provides for short-term subsidies for small businesses and would permit employers to purchase insurance through the Washington Basic Health Plan. The mandate will be phased in by employer size:

    - 500 or more employees by July 1995 (dependents by July 1996)
    - 100-499 employees by July 1996 (dependents by July 1997)
    - Fewer than 100 employees by July 1997 (dependents by July 1999)

    We note that while the legislation mandates employers to provide insurance, implementation of the mandate would require that Washington obtain an exemption from the federal ERISA legislation.

- **Individual Mandate**: The individual mandate requires every individual to have health insurance coverage by 1999.

- **Health Insurance Purchasing Cooperatives (HIPC)**: The legislation designates four regions in the state and mandates that one HIPC be established for each region. Based on the state's population, the legislation estimates that each HIPC should have at least 150,000 members. The Washington Department of Health will operate a central information clearinghouse to assist the HIPCs. The responsibilities of this clearinghouse include the establishment of a risk profile information system to permit the equitable distribution of risk among certified health plans.

  The HIPCs will be member-governed and owned nonprofit cooperatives that are certified by the Insurance Commissioner. HIPCs will be required to admit all individuals, employers, and groups and to make available to members every health care program offered by every certified health plan operating within the cooperative's region. They will manage centralized enrollment and premium collection and distribution among certified health plans.

- **Certified Health Plans (CHPs)**: CHPs are required to offer all elements of the uniform benefit package by July 1, 1995. They must offer prepaid per capita community rated premiums that do not exceed the maximum established by the commission. Geographic boundaries will be established within which they will obligate themselves to deliver the services required to any state resident within its service area. Supplemental services may be offered if they are community rated.

The legislation also provides for increasing the enrollment in the Washington Basic Health Plan and Medicaid. Washington plans to finance the expansion of state programs through various taxes, including "sin" taxes and taxes on nonprofit hospitals. The legislation designates the Washington Health Care Authority (an executive agency which now administers state employees' insurance) as the Consolidated State Purchasing Agent (CPSA) for state government. On or after July 1, 1995, the HCA will be merged into a single community-rated pool along with the Basic Health Plan, school districts, and state employees. Other provisions of the legislation include limited antitrust immunity through the state action doctrine for the formation of networks, the creation of a state-wide data system, short-term insurance reform, and public health financing and governance.

Mr. CARDIN. Mr. Thomas.

Mr. THOMAS. In looking at the Federal role, which is one of the things I am concerned about, you put first—and is there some suggestion that the dots following the suggested roles for the Federal Government have a hierarchical relationship or was it stream of consciousness?

For example, under the first one, you mandate participation by all parties in the system including employers and individuals. To the degree that States take somewhat different approaches, that may or may not make sense in terms of requiring the structure, and if we are going to create optimum State flexibility we may not necessarily want to have that dictated from the Federal level.

Mr. HELMS. I acknowledge this is a constitutional system with Federal roles and with States operating the system. I would suggest that the national Government needs to set the framework for this system and they should give States important operating responsibilities.

I am saying to you, though, that you can give States lots of flexibility, and I think you won't get enactment in many States of universal systems because requiring mandates is difficult for States to pull off in large part because of the financing.

Mr. THOMAS. I was going to say—and let me finish—if you do your second provision and make that fundamental in terms of a uniform financing system, then I think you will find they are much more interested in helping set up the structure if they have resources to pay for it.

And that is why I believe the second and the third point, a uniform benefit package to measure between States and what it is a State is supposed to do and a uniform funding mechanism to provide for that, really then makes somewhat less essential the structure under which that benefit package financed to the given amount of money operates. Do you agree with that?

Mr. HELMS. I agree with that. I am just urging us to recognize if we want to get to the goal—which I think the States have in all the work that I have done with them through the years—of universal access, we will have to require participation some way.

Mr. THOMAS. And financing——

Mr. HELMS. Is a key way of doing that.

Mr. THOMAS. And the uniform measurements between States, in terms of how they are treating citizens of the United States in terms of a uniform benefit package, to me, are most important.

Have you noticed States have some concern about the fact they have wanted to do some things but were not able to because of Federal laws, in terms of organization and structure? I notice sometimes the antitrust laws get in the way. Do you have any examples at all that might help us to understand if we pass some kind of generic fundamental enabling legislation that perhaps States could move faster?

Mr. HELMS. By far and away the biggest stumbling block the States face is ERISA. It precludes States from requiring participation, it precludes states from regulating or taxing self-insured plans, requiring all employers to offer it. Assessing surcharges or levying taxes may well be under challenge. So I think ERISA is the major stumbling block.

If you want to try some of these ideas, like reorganizing the market and doing purchasing cooperatives and you want to do this in rural areas, you have to let us take the principal funding sources in these areas like the Medicare population and the Medicaid population. So waivers under Medicare and Medicaid would be required as well. Clearly, some antitrust protection, or at least clarifying what is permissible, would be useful.

Mr. McDermott. Would the gentleman yield for a question following up on that?

Mr. Thomas. Certainly.

Mr. McDermott. Under ERISA, if you are mandating the employers to put something out for the employees, that is one thing. But if the States go to a residency-based system and then require employers within the State to put out a benefit, in your view does that change their position under ERISA?

Mr. Helms. I think we will have to find what the courts ultimately say on this issue. But as I understand how these statutes are being interpreted under a tax-financed system, a State would do would not be subject to an ERISA challenge. So if a State wants to tax finance the system, it could.

The reason why Massachusetts adopted the pay-or-play strategy was they believed that would be a way around the prohibition against mandates. however, many believe that this will be subject to a challenge saying that the pay part of that is really a mandate.

Mr. Thomas. The last thing we want to do is to leave States the option of coming up with something that they don't necessarily want as a first choice because the Federal Government refuses to respond in a meaningful way to needs that are out there. And ERISA was a response to a structure that was not uniform and required, and folks were fairly creative in terms of what their options were.

If we set up standards for opting out of the system, which in essence requires them to meet what we consider to be the minimum requirements of the system, and they still opt out, either in terms of financing or benefits delivered, I think you get a degree of uniformity with still the option of opting out available.

So I just am very concerned that, as we wait for the plan, States are moving forward. And if, in fact, the plan has a high degree of flexibility for States in it I want to make sure that we have provided a foundation for them to move as expeditiously as possible.

So, from my point of view, what I am more interested in in the package is the mechanism of financing and uniformity of the benefits and the enabling of States with either waivers, and I would much prefer enabling Federal legislation to allow them to choose the option that they want with a minimum of specific categorical requirements on the part of the Federal Government. I think we are going to get a faster national structure and certainly one more in tune with the people given the varieties that we have in the regions.

Thank the Chairman very much and thank you for the documentation. I have been looking for stuff like this. Thank you, Mr. Chairman.

Chairman Stark [presiding]. Mr. McDermott.

Mr. McDermott. I only want to ask one question.

There are two States that are not on our list here and I assume that it is because of problems. Massachusetts and Oregon are not on the list.

Tell us a little bit about what the problems were for those States because—certainly Massachusetts was very early; 1989 or 1988 they were talking about having accomplished a system.

Mr. THOMAS. Not on what list?

Mr. MCDERMOTT. On the list the Chairman passed out.

Mr. THOMAS. They are in your testimony.

Mr. MCDERMOTT. They are in the testimony, but I want to hear a little expansion on that.

Mr. THOMAS. I am with you now.

Mr. HELMS. Clearly, Massachusetts had a change in political leadership. And one of things we have to understand within a Federal system is that a change in a State's political leadership can derail a fragile consensus. That was a fragile consensus that was adopted in Massachusetts. In addition to political changes, Massachusetts had a major economic recession and probably concluded it did not have the resources to implement the program on the original schedule. They have not, however, legally removed their pay-or-play mandate. They have postponed it two or three times, and the date now is 1995.

Oregon, I believe, should continue to be on this list. In addition to having the Medicaid waiver that you are very familiar with, they also have enacted insurance market reforms, put voluntary subsidies in place and then—and if they fail to meet a target that they had set in their legislation for participation, their trigger for a pay-or-play mechanism would kick in. And they have—are well below the threshold that they set for the voluntary system to respond.

So, once again, we have further evidence that doing this with market reform and subsidies does not get us to universal access, and they are proceeding to develop plans now to implement the pay-or-play provision in 1995.

Mr. MCDERMOTT. I asked the question because I was in Oregon over the weekend, and they are clearly struggling, as is Ohio, with how to respond to the budget shortfall.

Mr. HELMS. That is an issue. Having the resources to pay for the extension of the Medicaid plan is very much an issue and could derail this, I recognize.

Mr. MCDERMOTT. It really argues in your reform efforts that there be some nationally standard benefit package and financing mechanism in place so that States have some way to operate within it.

Mr. HELMS. You are looking at the leaders here and, as I say in the written testimony, there are about half of the States—you don't get to ask me to name them—that are not very far along here, and I think they will take a real push.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Chairman STARK. Mr. Kleczka.

Mr. KLECZKA. No questions, Mr. Chairman.

Chairman STARK. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

One of the things that we need to have is data on utilization and cost as we look at developing national budgets on health care and

allocations to the States. In the State of Maryland we have fairly good information on utilization on hospitals and costs in hospital care, and we have passed legislation to try to get that capacity on outpatient services.

I am wondering what your assessment is as to the type of information that we have from the States on utilization and costs that would be useful to us as we struggle with how we are going to allocate the resources among the States.

Mr. HELMS. We are very actively working through the State initiatives in the health care financing reform program that is funded by the Robert Wood Johnson Foundation with some of the leaders that are trying to build systems of expenditure limits, targets and caps. Minnesota and Vermont will both testify, and they can tell you that States are quite ill prepared in this country to set expenditure limits. We are working very hard now to build a data capacity in those States, and I think it can be done. Tremendous strides have been made in Minnesota and Vermont to do that.

There is a considerable infrastructure we have to build to be able to develop a system of State health accounts. We have national health accounts that HCFA generates for the Nation as a whole, and we generally know how we are doing on spending, but we don't have comparable good State estimates of cost and utilization because we have not yet mandated nationally that we have a uniform data system.

I hope one of the things you do when you do pass national health reform is to assure that we obtain uniform national data from this industry.

Mr. CARDIN. What States are the leaders in developing that information on the State basis on their costs?

Mr. HELMS. Maryland, New York, are certainly two leaders because of the work they have done with all-payer, rate-setting systems. They are right at the top on the hospital side, and they are now beginning to develop those same systems for other payers. New York and Maryland both——

Mr. CARDIN. That was the right answer. I just wanted to make sure I got it.

You say we are going to need to put into place the infrastructure to develop uniform methods for determining utilization and cost, and yet we are going to need to take action on certain allocation of resources. Can you give us some—what type of task is it going to be?

Mr. HELMS. It is a big one and will require I think a major development effort. But you have resources in HCFA, the Agency for Health Care Policy and Research, and the Public Health Service which could be marshalled to build these data systems and capabilities. It needs to be charged to begin to develop this data capacity and to work with the States.

Mr. CARDIN. I guess what we are saying is we will need to develop the national guidelines for developing that type of data, and the States will have to develop or help develop it with us if we are to make certain assumptions and adjustments as we go forward on health care reform.

But it is one of the major areas that we need to focus on. And whatever States can help us in developing that will be helpful.

Mr. HELMS. And some States can be leaders. And what we will need to do is share the leading examples from States like Minnesota and Vermont on expenditure limits or New York and Maryland in terms of payment systems. So, however we are going here, we have to stay on top of what these States are doing and help translate that experience to other States.

Mr. CARDIN. Thank you.

Chairman STARK. Mr. Grandy.

Mr. GRANDY. Thank you, Mr. Chairman.

Dr. Helms, I don't know if I missed it, but under your call for uniform Federal guidelines, do you include malpractice and hospital antitrust reform? I don't see it in your testimony.

Mr. HELMS. I think it would be helpful to have some national standards on antitrust. I think the States can, through a States action immunity clause, indemnify the efforts to develop integrated delivery systems. But it is always helpful to clarify in the Federal system that we want to promote integrated delivery systems, if we do. And we do not want to hold the industry at risk when they begin developing those kinds of systems.

And right now I think we have inconsistent policy. We have a Federal Trade Commission and antitrust enforcement that——

Mr. GRANDY. So you feel that should be included under your guidelines.

Mr. HELMS. Yes.

Mr. GRANDY. Now let me go to ERISA. I want to understand the difference between ERISA waivers and preemption of ERISA, because it seems to me what States really want is an ERISA waiver so they can tax those self-insured companies which are now really kind of cordoning off a large body of the insured population and do not pay any kind of revenues to the State.

That is a different State flexibility option than providing a broad-based preemption to ERISA that would say if you have a qualified plan, a uniform benefit, you are a qualified ERISA plan and not subject to the State laws that would mandate certain coverages and certain restrictions against managed care.

It seems to me the real problem is the taxation issue, is it not?

If you wrote a broad preemption of ERISA and said any State that has a uniform plan, designed probably by the Federal Government, approved by Congress, then you don't have to comply with the State mandates, you don't have to worry about antimanaged-care prohibitions, you are still going to have a problem with the States getting revenues, right?

Mr. HELMS. Right. First off, you realize we don't now have this ability to exempt States.

Mr. GRANDY. I understand that.

Mr. HELMS. That is the first thing.

Mr. GRANDY. That is why people are asking for waivers in addition to the tax problems.

Mr. HELMS. I think there are two things they want.

The first is they want a way of requiring participation for all of their residents. And one of the ways to do that, given the cost problem that States have, is to mandate this on employers.

So they are wanting two things, the ability to require universal participation in the system, and they also are looking for taxing re-

sources to fund the underinsured. And both are needed. The self-insured plans represent a loophole if they begin to try to tax plans.

Mr. GRANDY. It follows, though, doesn't it, under any kind of plan, national or a national plan of confederated State plans, whatever we decide on, one of the uniformed guidelines would have to be, I would think, that fully insured and self-insured plans would have to be treated equally. Otherwise, you are carving out special interest kind of factions and allowing an opt-out of the system which is going to deplete the resources in the system you are trying to empower. Wouldn't you agree?

Mr. HELMS. I do.

Mr. GRANDY. So if you had a Federal financing system, whether it is a national tax or a provision whereby States could tax self-insured plans, you get around that problem, don't you?

Mr. HELMS. I think you could.

Mr. GRANDY. So is the best way to do that to impose taxes—either national provider taxes or payroll taxes or caps on deductibility of benefits at the Federal level—or to allow—amend ERISA or rewrite ERISA to the point where self-insured plans are no longer protected from taxation?

Which is the better way to go? The flexibility measure argues for allowing the States to get at those plans. The national approach is to create a one-size-fits-all kind of taxing mechanism which allows the States the revenue they need to offset the self-insured option. Which is better?

Mr. HELMS. I am not sure that I am prepared to say which is better. I do strongly affirm that we have to have—to get to our goal of universal access—universal participation. And I think it is not going to be possible to get universal participation without enabling States to require participation by employers. Unless we do, we will always have a situation where some employers are opting out of the system, which makes it much more difficult to set uniform cost control systems and so forth.

So I think we need uniformity. I would prefer to have this mandated by the Federal Government in terms of the financing and the participation. I think that is where the mandate ought to occur.

Mr. GRANDY. Would you put the mandate on the individual? Would you require the beneficiary, supposedly——

Mr. HELMS. We have looked at this. The mandate can be placed on the individual, or it can be placed on the employer. If the mandate is placed on the employer, there probably also needs to be a mandate placed on the individual.

Mr. GRANDY. When you say that, do you mean the mandate should be to pay or provide? That is a very pronounced difference in some of the philosophies on this committee in terms of what the mandate should be.

And if you mandate the individual to have the coverage and you mandate the employer to provide it, is that enough or does the employer have to copay? Could he share or does he just have to make access available to a policy that an employee can afford?

Mr. HELMS. Your answer to that question would be based on the equity issue and the ability to pay issue. As long as you are not imposing a mandate on those who don't have the ability to pay, then I think you can take the mandate approach.

I don't know that you are asking me for my political judgment about how best to do this.

Mr. GRANDY. I don't think anybody has made that judgment, Dr. Helms. I won't ask you to do it. That is one of the big unsolved questions.

Mr. HELMS. It is a tough issue, and it is a matter of the equity issue and how much you want to impose this burden on individuals.

Mr. GRANDY. Just to conclude—and this is my last point, Mr. Chairman—do you feel that State flexibility, even under its broadest tolerance, is going to require some kind of mandate imposed from on high, meaning probably this town, to States and through States to individuals, be they employers or employees or both?

Mr. HELMS. If you want this coverage to be uniformly available——

Mr. GRANDY. I am presuming that is a goal for everybody on this committee, because I have never heard anybody say I don't want universal access.

Mr. HELMS [continuing]. Then I think you will have to do it here.

Mr. GRANDY. Thank you, Mr. Chairman.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Thank you.

I am sorry I missed most of the earlier questions. But let me just ask you, as I read your testimony—as comprehensive as it was or maybe because it was so comprehensive—it wasn't fully clear to me whether or not you see the States now acting mainly to fill a void or mainly because in a country as large as ours we need diverse centers of experimentation?

Mr. HELMS. I think I have answered the latter: States traditionally have played major roles in this country with regard to implementing health programs. It is one of the advantages of the Federal system that you permit States to experiment so that you can learn from them.

But I also think the first premise of your question is also true, that States are being pushed by strong interests within the States to do something about this. They are both wanting to serve as laboratories to inform a national Government but they are also trying to address real cost problems that they have to get after, and they are very concerned about what is happening with this fundamental breakdown of the insurance industry and getting access to their people. I think it is both things.

Mr. LEVIN. So, based on your experiences, what do you think, clearly, would be better handled by States?

Mr. HELMS. As I say in this testimony, if you are going to try to reorganize the insurance market and develop purchasing cooperatives, I would leave to the States how many should be established and what geography they serve based on Federal guidance. I would leave to the States the job of trying to improve the delivery system.

The States traditionally have the responsibility now for training and licensing health personnel, and I think the national Government can help set standards there. But I think the States will need to develop and reorient the medical school training programs which develop health personnel to get a better balance of primary care.

For example, to achieve cost containment goals, you might for a while in this country want to impose rate setting from the national Government on the entire industry and on all States as part of the transitional period. But I think, longer term, you probably would want to leave to the States some flexibility to operate resource allocation systems whether that be capitated premium controls or State run payment systems.

So I would say that even in a universal system which mandates Medicare for all, that you would have, ultimately, a role for the States working with the Federal Government to do resource allocation. It is a traditional role they have had, and I would see them continuing to play that role.

Mr. LEVIN. So as you see the likely future, it is with a universal system, in a sense, but with 10, 15 truly different varieties of implementation?

Mr. HELMS. That is absolutely right. I can see a State like New York wanting to operate sector price controls for hospitals, nursing homes, physicians. I see a State like Colorado or some of the other western States like Washington not wanting to get into the detail of setting prices and wanting to operate these more managed, integrated systems, giving them perhaps a target premium and having them try to live within that framework.

So I see the States very much wanting to operate different cost control systems based on their cultures, attitudes toward regulation, et cetera.

Mr. LEVIN. And you see that system working, resulting in true cost containment?

Mr. HELMS. If you set the cap, they will live within it, and I think you have to hold them accountable to it. There will be a big issue about the extent to which you hold them accountable to it. If they are not able to live within it, you have a backup capacity that you can operate.

Mr. CARDIN. Would the gentleman yield for a moment?

Mr. LEVIN. Be glad to yield.

Mr. CARDIN. How successful could a State be in controlling its own cost within the States if their neighboring States don't have controls? We don't have any national controls. How successful can that be?

Mr. HELMS. There is some evidence to support that cost control will have to be imposed nationally. However, there is also evidence that States like New York and Maryland, even though neighboring States did not impose those same systems, were able to get significant savings out of hospital rate setting.

Mr. CARDIN. So it will be difficult for us as a Nation to control costs by allowing the States without national guidelines——

Mr. HELMS. I am clearly saying that.

Mr. MCDERMOTT. If the gentleman would yield.

Mr. LEVIN. Certainly.

Mr. MCDERMOTT. It is interesting to look at this list of States that have been involved in health care reform. All are edge States, except for the State of Maryland, which is more involved in the east, but if you look at Hawaii, Florida, Minnesota, Vermont, Washington, it is all people out there who can see some way to do their own thing.

I keep thinking about Missouri where you have St. Louis on one side and Kansas City on the other. How do you put those State things together when you have these big cities that lap over into the next State? It really is an interesting question how Missouri puts together a system just to deal with Missouri.

Mr. THOMAS. Would the gentleman yield briefly?

Mr. LEVIN. Sure.

Mr. THOMAS. To put it in some context, though, nationally, if you take Massachusetts, Michigan, and California, the Nation can dance to Motown and the Nation can watch "Cheers," but we still to a certain extent, you know, each speak somewhat differently and health and wealth are defined somewhat differently. So I think there is a regionality to some of these concerns.

But, as I said when I was speaking, and I agree with everything that has been said, from a financial and a benefits point of view, I cannot see how it can be done on a State-by-State basis, especially in terms of those States that are not definable, really, as units or entities today. May have been at some time. The Connecticuts, the Rhode Islands—Nancy is not here—but in terms of the population structure and the shared borders and the ease with which people can move across, the necessity with which they move across State lines clearly augurs on a financial and a benefits structure to run it from a national level.

But the delivery, the mechanics of how it is done, I think, can be allowed for some regional diversity to fit in with the structure.

Mr. LEVIN. Do you want to respond to that?

Mr. HELMS. I will agree with that. I think the system will evolve——

Mr. LEVIN. I thought you said you did not——

Mr. HELMS. I agree we have to be clear about where we want the flexibility and where we want some imposition of national standards.

On the delivery system side, it will evolve differently, and there are different approaches and attitudes toward managed care in those systems. I think you can let the system evolve differently within those States.

Mr. LEVIN. You call it a delivery system. I think—as Mr. Cardin and Mr. McDermott implied—under your model the funding mechanisms also are diverse.

Mr. HELMS. They are, but I am arguing in this testimony that we need national standards for the financing system.

Mr. LEVIN. But standards——

Mr. HELMS. A national financing system.

Mr. LEVIN. And a national financing system.

Mr. THOMAS. And national benefits.

Mr. HELMS. Sir, we can remember Michigan, which had a very modest effort with a one-third share subsidy plan, and when Michigan hit an economic recession, there went that subsidy plan.

It is hard to sustain the financing for even subsidy programs at the State level, and I think we have to make this as a commitment nationally. A State can make the commitment, but I worry when it gets into a tough economic crunch, how firm that commitment will be held. I would hope we could come together and do this as a national Federal system and give some important roles to the

States to operate on the delivery side and on the cost containment side. But you set the framework nationally.

Mr. LEVIN. All right. I am not entirely sure, then. You draw a pretty rigorous line between funding the benefit structure and delivery, and you put funding and the benefit structure on the national side and delivery on the State side.

Mr. HELMS. I do.

Mr. LEVIN. OK.

Chairman STARK. That makes sense to me.

I was going to ask you more about the uniform financing system, but I think you have covered that.

Give us a quick estimate or outline of what would happen in your opinion, particularly in those States which you declined to mention but certainly are on your short or long list. How many people would end up without coverage if we didn't have a mandate on employers and individuals? What is the downside of not doing that?

Mr. HELMS. As you will recall, the projects funded under the RWJ health care for the uninsured program were only able to get market penetration of 10, 15, 20 percent using subsidies to encourage voluntary enrollment. Oregon has had a similar result from their voluntary subsidy program. They also did insurance market reform. We will have another test in Florida. They are about to restructure the health insurance industry and try to substantially improve access. But all the weight of the evidence thus far where we have done this voluntarily shows we get about 15 to 20 percent of the market. It is very hard to get very small firms to purchase it voluntarily.

Chairman STARK. Define that. Part-time employees; 15 hours, working two jobs a week?

Mr. HELMS. Firms of less than 10, what we call the small group market.

Chairman STARK. How many people do you guess would be involved in that group if we are not careful?

Mr. HELMS. I think it is at least 8 or 10 percent of the population under 65 that would not obtain coverage without a mandate.

Chairman STARK. Of the population?

Mr. HELMS. Of the total population that would remain uninsured if we did not go to a mandatory system.

Chairman STARK. OK. The other question that you raise is that States need a great deal of technical assistance. I will let you tell us what you mean by that, but I guess what I am looking for is this: Let's assume that we were to write a bill and require that States meet certain standards or else I presume the Federal Government would have to provide either coverage or insurance or whatever for the States that choose not to, fail to or for some reason cannot.

Let's assume you have 15 or 20 States that you think can handle this, OK? The other States—what kind of assistance would they need? Are there some that would never be able to clear the hurdle? And how long, if you were writing the legislation, would you have to allow for all this to grind through State legislatures? Can you give us a little explanation of that?

Mr. HELMS. The incentives that you put in place for States—for example, if you start collecting taxes related to this system—is going to have a much stronger incentive for those States to say they are ready and to get ready than my answering you about their capacity to undertake these responsibilities. But it is at least a 2-year job and probably longer before States have the operational capacity.

As I noted in my testimony, I also remember that in Germany, when they brought the East German system in, they did it in 90 days. So if we have the clear resolve to do something, we just do it. And this is not going to be easy, and we are going to have to learn and to let the States begin to build this capacity. I think we will probably need a long transition period to national reform.

I urge that we get started now on helping these States get ready and building the capacity to operate the data systems, to begin restructuring their delivery systems. Those are things we could do now.

And, as you well know, in then 1980s we decreased and then eliminated Federal funding to develop planning and policy capability. Now, the Federal Government could help the States by saying get out there now and start developing some of these systems that you are going to need.

And technical assistance. What do I mean by that? There are leaders—and, you know, if you are in a State and busy doing your job, you don't have time to request the research about what others are doing. Organizations like ours, nonprofit centers, and there are others, can bring these States together as we will do this week when we convene the States to look at where they are in health care reform and what can be done to help them get better prepared.

In addition to the convening role, technical assistance involves developing materials. It is also going out there and working with the States, showing them how to use this data, helping them develop models to estimate the impacts of cost and access expansion. There are a lot of things involved in doing it, but I think you have to build this capacity, and it is a traditional role of the Federal Government to support the development at the State level.

Mr. THOMAS. Mr. Chairman, just briefly on that——

Chairman STARK. Sure.

Mr. THOMAS. As anyone knows if they follow a presidential race, there are some States candidates tend not to go into because of the population, size. And if they are going after votes, they go to certain States. Interesting that these States are fringe States. And if you take a look at most of the other States that are moving significantly in the reform area, they are also populace States. They are the States where the people are.

To talk about a timeframe of requiring all 50 States to meet some set standard does not make a lot of sense to me if a State has a State legislature that meets 6 weeks out of a year and that, coincidentally, also has one representative to the national legislature.

It seems to me that our job will be to put a structure in place which will be grabbed at by a number of States who are looking for things to hang on to in terms of uniformity, especially in terms

of financing, in terms of a benefit structure, and that we can allow this within a reasonable timeframe, and then take a look at where the problems are.

And the problems will be those States which currently have problems in large part because of geography, for simple delivery of health care, regardless of what it is and where it is. They have fundamental problems that are not going to be addressed by this kind of a system.

I think for us to talk about a framework in which people are not going to respond—the States are ahead of us right now. They are going to continue to be ahead of us. We need to provide the federally necessary structure of financing and uniformity and enablement in areas that they can then continue to move rapidly. And within 5 years all this will be behind us.

If we talk about mandating, forcing and requiring people to all pass through the same conceptual structure to get a uniformity that is not necessarily wanted or desired, we will only slow down and prolong our effort to provide health care to all Americans.

Mr. HELMS. You are right about the sequencing of these state legislatures, when they come into session. I think it will require a 2 to 3 year timeframe so these legislatures can enact necessary enabling legislation. They are already anticipating what this national Government is likely to do, and they are already beginning to try to move toward what they think the national consensus is going to be.

By looking at the most recent plans enacted in Washington State and Florida, and even some of the reforms that have recently been enacted in Maryland, you see they are anticipating where a national Government is going, and they are doing what they think politically they can do.

So I think, in summary, you are right that we cannot leave some of these States behind. I am arguing though, for them, you are going to have to set very clear guidance so they know where they are going, and you will have to put some assistance in there. We treat the States as though they are equal, but having worked with New York State and North Dakota—and no aspersions meant to the staff in North Dakota, but it is a different capacity there. It is much smaller. The technical skills are not what they are in New York State.

Mr. MCDERMOTT. Mr. Chairman, may I ask a clarifying question?

Chairman STARK. Certainly.

Mr. MCDERMOTT. One of the things we were struggling with in the single-payer bill was what role the States should have. And you are suggesting one way to get things moving if the Federal Government collects the money is to provide an incentive to the States. So we struggled with the question of maintenance of effort, and we set an arbitrary 15 percent match to come from the State level, since that was about what was spent on Medicaid by States across the Nation.

Can you comment a little about that whole question about what States ought to be required to put into the State pot?

Mr. HELMS. I will ask you to ask Anya and Mary Jo, who will follow me, but they accept the idea maintenance of effort as a rea-

sonable expectation from the national Government. I think the States generally accept that, but you can ask them because they have been working with the State governments in assessing what ought to be their financial responsibility.

Mr. THOMAS. If we are going to get into the sensitivities of plans, national uniformity and finances, at least from this gentleman, it was necessarily assuming the Federal Government was going to collect it. There are a number of ways in which the Federal Government can make a decision which is uniform on all people short of requiring them to pay the Federal Government and have the Federal Government disburse.

Mr. MCDERMOTT. I was not making a final decision. I was just talking about the decision made at the Federal level about how much money the Feds would acknowledge and how much the States had to acknowledge as their present contribution to health care.

Mr. THOMAS. And the mechanics of how that is done between them?

Mr. MCDERMOTT. Yes. Some States are spending more than others and would like to get out of it, so that is what we are struggling with.

Mr. THOMAS. Others are not spending as much as they should, and we would like to get them more involved.

Mr. MCDERMOTT. Of course.

Chairman STARK. If there are no further inquiries, I would like to thank you very much. I am sure we will have some chance to discuss this further as this whole health care issue unwinds.

Our next panel will be comprised of witnesses from the States of Hawaii, Florida, Minnesota, Vermont, Washington and Maryland. One of the representatives with us this morning is an elected official, and I would yield to the distinguished gentleman from Washington for an introduction.

Mr. MCDERMOTT. Thank you, Mr. Chairman. It is a distinct honor to introduce Senator Janice Niemi from the State of Washington. She has worked as a lawyer and then as a superior court judge and then chose to enter the legislature, which shows the good choices she can make. She has been everywhere but finished in the best place and is actively involved in the health care reform efforts in the State of Washington. And, most importantly, when I left the State legislature she took my seat in the Senate.

So I would extend a warm welcome to Janice. She is very knowledgeable, has been involved in it for a long time, and I thank her for giving her perspective on the politics of the State.

Chairman STARK. Ben Cardin.

Mr. CARDIN. Mr. Chairman, I would like to welcome John Colmers. The members of this committee have heard me mention many times the unique Maryland all-payer rate system for hospital care. The truth is that the success of our program has really been because of the quality of the people who have led our Health Services Cost Review Commission. In its 20-year history I think we have only had three executive directors, and Mr. Colmers has done an outstanding job in heading that commission in our State of Maryland, and we are all proud of the work John has performed.

I also see Stan Lustman here, and others in our State, who have been very helpful in providing the professionalism to make sure that our system works.

Chairman STARK. Mr. Thomas.

Mr. THOMAS. Mr. Chairman, I want to welcome Dr. Sybinsky. I have not had a chance to look at Hawaii's health care system and am anxious to go out.

Chairman STARK. Dr. Sybinsky, welcome.

Mr. Douglas Cook is the director of the Florida Agency for Health Care Administration, and I want to welcome you to the committee.

Miss Mary Jo O'Brien, deputy commissioner of the Minnesota Department of Health. We are pleased to have you with us.

Miss Anya Rader, deputy chief of staff for Governor Howard Dean, who is a physician, is representing the State of Vermont.

I think that all of the witnesses probably heard in my opening statement, the issues that I asked you to address, and we will have you go down the line and sort of summarize perhaps those areas in which your State feels you have unique features in a particular area or in which you might differ with the previous witness's comments about what the States should do and the Federal Government should do.

And, as a matter of comity, we would ask Senator Niemi to proceed first and then follow up in the order as you appear on the witness list. Senator.

STATEMENT OF HON. JANICE NIEMI, WASHINGTON STATE SENATOR

Ms. NIEMI. Thank you, Chairman Stark, committee members.

My comments may be slightly different. Since I am the only politician on this panel I think that I will talk about health care reform more from a political angle.

I appreciate Congressman McDermott's remarks. I could give the same kinds of remarks for Congressman McDermott.

I have been in this health care business for about 11 years, and I have authored some bills I thought were wonderful ideas and great reform, a high-risk pool among other things, and they ended up being Band-Aids. I guess that is why I feel strongly about a whole reform system.

I have given a statement which I hope answers all of Chairman Stark's questions and gives a history of health care reform in our State. And I stand by that statement except that I think that the word consensus crept in there, and I would like to note that we need a lot of resolve and we need a lot of work and we need compromises to get health care reform, but the word consensus gives the group a blackball, and we have to recognize the fact we cannot do it with consensus.

I would also like to talk a little about why we ended up with an employer pay system. In 1990, we set up a very good commission that came up with some recommendations that our legislation was based on, and that commission voted by a very narrow margin, 8 to 7, to have a residency-based system. And the reason it was so narrow was because everyone was so concerned about the political ramifications of a residency-based system as opposed—or a single-payer as opposed to an employer-based.

Our State House of Representatives, which was Democratic both in 1991 and 1992, passed major health care reform legislation based upon a residency-based system. That was killed in the Senate for 2 years. Both the Senate and the House are now Democratic, although this is a somewhat bipartisan effort that you are seeing.

I am involved, although I have always been in favor of a residency-based system, I think as much as anything because of Lyndon Johnson's—President Johnson's remark about better to have somebody inside the tent. And I feel very comfortable with this legislation that we passed. I think it is a framework. Although it is employer-based system, I think it is a framework that can do anything.

Yes, we have coverage for everyone by 1999, although I think it is going to be very difficult for many of the reasons that are already stated. Yes, we have specific policies and programs for universal access. We are assuming universal access. And, yes, we did raise some revenue, although the revenue went to expand probably Congressman McDermott's biggest contribution to our health care which was a basic health plan, that is a plan of State subsidization for the working poor. They pay some also, and we expanded that.

I think everyone got a little dewy-eyed about children, so we expanded it a lot more by using most of the money for a Medicaid match for children. And we are not really getting into the sticky problems.

We did some other things in the bill that I think are important and I would recommend and that is we pulled in, or at least mentioned, labor and industry. I think it is important to do what Garamundi is doing in California with its 24-hour plan, and that is to realize that health care is health care, and eventually we are going to have to pull in workers comp and not have that double system, and it should help employers, too.

But we did make a promise to all the workers in this country that there would be no copay and there would be no payment at all for an injury on the job, and that is a detail that is tough to work out, and we have to live up to that commitment.

We also made a small dent in our bill to take care of personal injury coverage which is another overlap. We didn't get too far. Our friends, the trial lawyers, didn't want too much, but I think we took care of first party coverage. We had a lot of fail-safes in the bill. If we don't get an ERISA waiver, and I cannot emphasize how important that is, and I don't think we will, then we have a feasibility plan for residency-based system, and we are prepared to swing into that.

Lawyers disagree. I am a lawyer, and I disagree with a lot of other ones on whether a residency-based system would, in fact, get around ERISA. I believe it would. We have a very good west coast law firm which has given us a memorandum—gave the commission a memorandum—and it was convincing to them that we can, in fact, if we have a residency-based system not have to be as concerned about ERISA. And I think the prior speaker said something about that.

We made a lot of compromises. The employer base was one.

I want to mention some of the things we didn't solve. We kicked ahead, and every time we looked into these things, we did not solve them. You come up with—the problem with under an employer-based system, you really cannot solve it. We cannot solve small businesses. I don't know what we will do about that. In fact, we excluded migrant and seasonal workers, and that was somewhat of a tragedy.

We cannot deal with cost containment without pulling everybody in. The 50 percent of our State that we will be covering include the indigent, they include the people we subsidize, they include Medicaid, some Medicare subsidies. And the businesses who will benefit from this and who possibly will be able to hire healthier workers will benefit and won't help us with cost controls.

I realize the red light is on. I would like to just do a little——

Chairman STARK. Why won't they help you with cost controls? I am missing something.

Ms. NIEMI. By large purchasing we will be driving down costs. We will be making—the State will have a benefit package. We do have a uniform benefit package, and they can bargain for supplemental benefits. They will benefit from all of that, but we won't benefit from——

Chairman STARK. They won't pay any of their savings. We run into that, too.

Ms. NIEMI. Right.

Mr. THOMAS. Senator, you said you were a politician, so you know what those lights are for. Most of our witnesses do not. So pretend you are not a politician. You are the last panel, so go ahead and make your points and don't pay too much attention to the light in front of you.

Ms. NIEMI. All right.

We had a lot of tough issues. Everybody wants in. The chiropractors want in. The massage therapists want in. I think we did a pretty good job of making our benefit package somewhat loose. We have a strong commission, and they will decide what that benefit package is. If people can contribute to our health care they will be in. No one was specifically excluded.

You can or cannot get a plan with dental care. Mental health is always sticky, and I think we kicked that to the commission. I think they will do a good job. We provided for Medicare, two Medicare supplement options, either with prescription drugs or without, and I think we can deliver on that.

Research is not in. We have a big research facility, and they really wanted in. We will have to take a look at that later on.

We don't have enough primary care providers. We set up a system to try to make the universities graduate a certain number in a certain number of years. They were not happy about it, but that is one of the things.

I want to talk a little about the politics of this, though. We got a big onslaught. The reason we went to an employer-based system was because the Governor, the Chairman, Senator Talmadge, who did a wonderful job in passing this bill, all believed that the way to do this politically and the way to get business involved was to have an employer-based system, knowing that, of course, most of the larger employers would not be covered by it.

That did not happen. In fact, they contributed at the end to probably the biggest political onslaught that I have witnessed in 11 years. Television and radio and newspaper ads and phone calls to try to stop it, but everyone wanted health care reform, and I think that that translated into people trying to get more perks for other people, but it did not stop it.

But we did have cooperation. We had a lot of cooperation from physicians. One of the Republican conference committee members is a physician, Dr. John Moyer and he contributed a great deal. Even voted for the bill. Did a lot for rural health, that kind of thing.

The medical association officially probably did not endorse but unofficially were very helpful.

Lawyers had some problems with it, both defense and trial lawyers, but in the long run they were helpful.

The hospitals went along and were a big help in passing this.

The large businesses fought it, as I said, and the small businesses fought it, with legitimate reasons, and really they are the stickiest, thorniest problems.

And, yes, we are going to have a study, and, yes, we are going to try to handle it. And we did things like set up a pool to subsidize them, talked about tax breaks, did a lot of things. But every time you get into something like that you realize that universal—that a residency-based system is the only thing you can do to deal with that.

Chairman STARK. Thank you.

[The prepared statement follows:]

**STATEMENT OF WASHINGTON STATE SENATOR JANICE NIEMI
TO THE COMMITTEE ON WAYS AND MEANS, SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
8 JUNE 1993
RAYBURN HOUSE OFFICE BUILDING ROOM B-318
WASHINGTON, D.C.**

Good morning Chairman Stark and members of the committee. Thank you for the invitation to testify today on Washington State's efforts to confront one of the most vexing problems facing our economy and our nation -- containing health care costs, while distributing needed care to all.

I bring you greetings from the Chairman of the Washington State Senate Health and Human Services Committee, Senator Phil Talmadge; prime sponsor and a principal force for passage of our 1993 health care reform package. His efforts, together with those of Senate Majority Leader Marc Gaspard, their House counterparts, Health Care Committee Chairman Dennis Dellwo, and House Speaker Brian Ebersole, combined with those of our energetic Governor Mike Lowry to overcome significant resistance and bring about this major legislative change. I was pleased to serve as a member of the conference committee which produced the final version of the Washington Health Services Act of 1993.

As an eleven year veteran of the state legislature in Washington, and an active participant in health care reform efforts during all of those years, I am eager to provide any help I can as you move the nation across the very fundamental public policy thresholds we must cross to reform health care. In my time with the legislature, I have experimented with a high risk pool for uninsurable persons, with more aggressive health care purchasing by the state, with endless Medicaid expansions and experiments, with reform of our state's mental health system and, as the Ranking Senate Minority member on the budget for several years, with using that process to contain costs and assure access.

All of this tinkering with federal and state programs has taught me that only a fundamental redefinition of the government's role in health care can contain costs and assure universal access.

To explain that conclusion, I want to summarize our state's experience with the health care crisis, describe the problem as we view it, say a bit about the politics we encountered, and finally summarize the key elements of the Washington Health Services Act of 1993.

In my view, this debate is about the extent to which efficient and cost effective treatments to prevent illness and injury and to treat disease are: a) a public good to be assured through government intervention, b) a commodity to be bought, sold and distributed as an optional benefit to those of means, or c) compensation for work, given only to those whose employers are enlightened enough to look after the health of their work force.

Washington State's legislation assumes that a minimum level of health services is a public good, and that providing cost efficient universal access amounts to a simple updating of the government's traditional role of protecting and promoting public health. This assumption drives the need for major reform not only of the financing and payment systems for health services, but also of the substance of health services themselves.

WRESTLING WITH THE MONSTER — 20 YEARS OF BAND-AIDS

Like most states, Washington struggled with health care costs as far back as the early 1970s. We were among the first to establish a <u>hospital rate setting</u> commission. This, along with <u>health planning and certificate of need</u> was intended as a first waive assault on costs. It was to be followed by additional federal and state policy to assure access and to contain costs.

Instead by 1983, we found our Hospital Commission only partially successful, because, among other reasons, hospitals had begun "unbundling" their services from the hospital umbrella to avoid rate regulation. This gave us our first look at how elastic and evasive the health system can be. We found health planning and certificate of need captured by the health care establishment. And we found no significant moderation in costs.

Enter <u>the era of competition in health care</u>. In 1984, we strengthened our Hospital Commission and, to foster an emerging interest in competition, we allowed discounts from state set hospital rates. By now, charity care had come to be seen as a major source of cost shifting between the public and private sectors. So we resolved to develop a program to finance more rationally care for the growing number of people who seemed to be turning up in hospital emergency rooms with no health insurance.

Also, during this time, we began watching our own state government's health care purchasing practices more closely. We discovered that we could moderate the effects of rampant health care inflation on the state budget by becoming <u>a more aggressive purchaser of health care</u> for state employees, through the Medicaid program, in our industrial insurance program and elsewhere. We did this by establishing a consolidated state Health Care Purchasing Authority, by encouraging managed care in the Medicaid program, by mandating utilization review in the medical aid fund of industrial insurance and by employing other cost control strategies.

By the late 1980s, we began to see the results of these efforts. We had made modest inroads in cost increases for some publicly funded care. But we began to see dramatic increases in the numbers of working people without health insurance as small businesses were pushed out of the market. Hospital discounts enabled more aggressive purchasing by government and big business. However, this, coupled with the insurance industry's efforts to make health insurance affordable for low risk groups through various market segmentation devices meant that small businesses were paying much more than larger firms for comparable coverage. They could not afford it, and as they dropped out or cut back, we faced an estimated 17% of our population with no health insurance in 1986.

To begin dealing with this, in 1987, under the creative and very able leadership of then state Senator, now Congressman Jim McDermott, we established the <u>Basic Health Plan</u>. It provided a basic package of health benefits through managed care to some 20,000 low income, working families. Ultimately this program would serve as the basis for expanding subsidized care under our 1993 health care reform scheme.

In addition, we responded to the reduction in benefits and exclusion of many dependents from the private insurance market by taking advantage of virtually every <u>optional expansion in the Medicaid</u> program available. We expanded access to pre-natal and maternity services, provided more mental health treatment, expanded screening and treatment for children through the Early, Periodic, Screening, Diagnosis and Treatment program, expanded personal care for the chronically disabled, expanded case management and other services for persons with AIDS, expanded eligibility for medical care for children and more.

By 1990 it was clear that we had reached the limits of our state's ability to expand coverage and to also continue to absorb rampant health care spending increases. From 1980 to 1990 our state's public and private health care bill increased by 153% while per capita income increased only about half that (75%). And we still had 11% to 14% of our citizens with no health insurance. The Boeing Company, our state's largest private employer, announced that their 10 year projection for health care spending showed they would spend in excess of $19,000 per employee by the year 2000 unless change occurred.

In 1990 we established a study commission to recommend a more comprehensive solution to these problems. The 17 member body empaneled some 32 of our state's top experts in health care and involved no less than 1500 of our citizens in an exhaustive two year, public study effort which not only documented our dilemma, but also provided some unique insight into its nature. The Commission completed its work in December 1992 with a report containing no less than 75 recommendations for fundamental reform of our health care financing, payment and delivery system. This effort, established the intellectual base for health care reform.

As this study process was reaching its preliminary conclusions, the Democratic state House of Representatives passed health care reform based upon a residency based model in 1991 and 1992. In both years, the bill was killed by the Republican Senate.

Finally, this year legislative policy was enacted with passage of the Washington Health Services Act of 1993. For those who may be interested several copies of this report, the legislation and some explanatory material have been given to your staff.

THE PRESENT WASHINGTON SOLUTION — PROGRESS IF NOT PERFECTION

Having understood all of this, our state's Health Care Commission recommended that the state adopt a far more unified, rational and publicly oriented health care system. We adopted most of their recommendations in our recently passed legislation. For the most part, I feel the reforms represent a sincere effort to marry the benefits of personal choice and private initiative with the efficiencies and protection of standardized, and publicly regulated enterprise. But we failed to embrace what I think is a central Commission recommendation.

By a narrow one vote margin, the Commission recommended that we establish a single state sponsor to collect needed revenue and to fund our citizen's choices of competing, publicly regulated insurance plans. The rationale was simple. A single sponsor could more efficiently collect and distribute funds. It could more efficiently level inequities resulting from age, geography, family structure, medical condition and other factors. It could provide a more visible, more publicly accountable mechanism for a social decision on the allocation of resources for health care. And a residency based system would not be subject to ERISA.

In my view, the residency based system recommendation failed political, not policy muster in our state legislature.

As it happened, we found it very difficult to craft a seamless system based on a patchy and deteriorating commitment by employers to hire full time workers, much less to provide them adequate health insurance. Handling job changes and moves was very difficult, as were part time, temporary and seasonal workers. In fact, we excluded most seasonal workers, at least for now.

But the prevailing view this year in our Washington was that employers wanted a role in managing health benefits, and that their participation would help satisfy the private sector's desire to control financing more directly. Some felt business is better equipped to contain costs than government. Others were frightened by the prospect of the tax increase it would have taken to transfer all employer premium payments to the state treasury. It would have doubled our annual state budget overnight. Politically it was hoped that an employer based system would bring cooperation from the private sector; this did not happen.

It remains to be seen whether business will take their role as prudent purchaser seriously under our managed competition scheme. And if they do, some wonder whether the result will be the kind of cost control we all seek.

But for now, we have embraced the notion of employer based, managed competition on the theory that competitive incentives will drive costs down. Failing that, we have premium caps and managed care. Failing needed Congressional permission to override ERISA and implement our employer based plan, our legislation directs consideration of a residency based system.

In my view, the purpose of health reform should determine the debate between employer based health care and a residency based system. If our goal is to make efficient use of resources to maintain and promote our health, a single financing structure for at least proven effective services seems most wise. If this requires uncoupling health care from employment, perhaps we should. But that will take far more resolution about our purpose, and far broader consensus on the point than we had this year in our state.

As we seek to work with you on our needed exemption from ERISA, we shall both learn more about our society's readiness to dissociate health benefits from compensation for work. In that process, I fear we may all be reminded too often what we learned in Washington state this year --- ours is the art of the possible.

OVERVIEW OF THE WASHINGTON HEALTH SERVICES ACT OF 1993

Goals and Purpose. The new Washington law seeks to redirect the substance and distribution of health services in the state using a system of public mandates, public regulation of the private health insurance and provider systems, aggressive public and private purchasing strategies and public subsidies for those of modest means.

The legislation's central purposes are 1) to stabilize health service costs by keeping rates of increase similar to rates of increase in personal income, 2) to assure access to essential services for all residents, and 3) to improve the public's health.

The legislation will accomplish these purposes by a) re-regulating health insurance in the public interest, b) requiring all state residents, all employers and state government to purchase or subsidize the purchase of a uniform package of effective health benefits for no more than a maximum, community rated premium, and c) providing for the expansion of core public health functions.

The Regulatory Structure. Under the terms of the Act, a full time, five member Health Services Commission will determine the specific scope and duration of benefits, and will set a maximum premium for a legislatively outlined uniform benefit package. In addition they will prescribe a series of regulations to govern certified health plans.

By July 1995, only certified health plans may offer the uniform benefit package. Certified health plans will be regulated through the state Insurance Commissioner and must adhere to a comprehensive set of regulations to contain costs and ensure access. These include accepting open enrollment, prohibiting balance billing, accepting only pre-paid, capitated payments, offering the uniform benefit package on a community rated basis, abandoning a variety of medical risk isolation and avoidance strategies such as medical underwriting and exclusions based on pre-existing conditions, conforming to uniform claims processing, billing, payment and data collection standards and more.

Employers of more than 7,000 Washington residents can self insure, but their plans would have to offer at least the uniform benefit package for no more than the maximum premium and would have to meet most of the other standards which apply to certified health plans.

The Premium Cap. Once the maximum premium is established, the legislation contains specific limitations on the rate at which it may increase from year to year. In essence, the rate of increase is capped and driven down at the rate of 2 percentage points per year until it tracks with the 5 year rolling average increase in per capita income in our state.

The Individual Mandate And Supplemental Benefits. All Washington residents must be enrolled in a certified health plan by July 1999, and must purchase at least the uniform benefit package by that time. Supplemental benefits may be insured only through certified health plans. While they are subject to prior rate approval by the state Insurance Commissioner, supplemental benefits are not subject to the premium cap. There is no restriction on who may purchase supplemental benefits. They may include any service or level of service not included in the uniform benefit package.

The Employer Mandate. In July 1995 employers of 500 employees or more must offer a choice of no less than three certified health plans to their employees and must pay no less than 50% of the premium of the lowest priced plan. In July 1996, the same requirement applies to employers of more than 100 employees. In July 1997, all employers must comply. In all cases except the last, employers must extend coverage to employees' dependents within twelve months. For employers of less than 100, this deadline is extended to 1999.

Part time employees and some seasonal employees are included within the employer mandate. Employer premium shares are prorated, based on hours worked.

However, seasonal workers and their employers in the agricultural production or harvesting, tree planting or harvesting, and food processing industries are exempt from the terms of the act pending the results of a study to determine how best to include them, and affirmative action by the legislature.

Mitigating the Impact on Some Small Businesses. Among our most difficult political challenges was responding to the concerns of small businesses who do not now meet the minimum insurance requirements contained in the Act. While such firms are a minority of businesses employing 100 or less persons, they became highly vocal in their opposition to the employer mandate. To mitigate the impact on these firms we 1) reduced the comprehensiveness and cost of the uniform benefit package, 2) provided that no less than $150 million would be

available for assistance grants to qualifying small businesses when the employer mandate becomes effective, 3) required a small business impact statement to be submitted prior to full implementation, 4) authorized a recommendation on extending a business tax credit for small businesses covering dependents, and 5) made a special low cost purchasing option available for businesses.

Health Insurance Purchasing Cooperatives (HIPCs). Four regional HIPCs are established as private, member controlled organizations. Each must serve a separate geographic area, must offer open enrollment to any resident or business in their area wishing to join and may contain no fewer than 150,000 members. HIPCs may not bear financial risk or become certified health plans. They must offer all certified health plans (CHPs) within their region to their members, must provide consumer oriented information on CHPs to help in judgements about relative price and value, must provide for centralized enrollment, premium collection and billing and serve as an ombudsman for HIPC members.

Industrial Insurance and Personal Injury Protection. Many of us feel that there are savings in eliminating the duplication and less than aggressive management of several public and private special purpose health insurance programs. Accordingly, the Washington legislation requires a plan to integrate the medical aid portion of our state industrial insurance program with certified health plans, provided certain conditions are met. Among these conditions is keeping the promise that there will be no out-of-pocket costs for any workplace injury. To aid in developing the plan, pilot projects involving managed care and industrial insurance are authorized.

In addition, the legislation targets the duplication in health coverage which may exist between certified health plans and property and casualty insurance, by eliminating coverage for first party insureds and by requiring a study to suggest methods of integrating other coverage with that provided by CHPs.

Consolidated State Purchasing. The legislation seeks to build on our state's success in consolidating public expenditures for health services in a single state health care purchasing authority. Our state Health Care Authority will begin purchasing health insurance for all of our state's teachers in addition to state employees by the fall of 1995. Our Basic Health Plan, our community clinics, our ferry system workers and, with approval of necessary federal waivers, our medical assistance program, and ultimately perhaps federal medicare program expenditures may all be brought together under the purchasing authority of this single agent.

Expanded Options for Employers. In addition to the ability to purchase CHPs directly, or through HIPCs, employers of any size may opt to purchase the state brokered Basic Health Plan (BHP) to meet their obligations under the act. If this option is selected the employer's obligation is limited to a percentage of the premium based on the average cost of the program for a single adult.

Expanded Public Subsidies. The state's current subsidized program providing managed care to the working poor, the Basic Health Plan (BHP), will be expanded to include an estimated 115,000 persons by July 1997. Its benefit package will equal the uniform benefit package in July 1995.

In addition, the legislation provides funds to expand our state's Medicaid program through managed care to all our children whose family incomes fall below 200% of the federal poverty line. This will expand coverage to some 180,000 additional children in our state by 1997.

The Uniform Benefit Package. The uniform benefit package is specified in the legislation to be the same set of essential services now provided through our state's Basic Health Plan, with the addition of prescription drugs, limited mental health and substance abuse treatment, children's preventive dental care and reproductive services. The BHP package contains a full range of preventive services and health screening with no co-payment requirement in addition to inpatient and outpatient care, emergency and limited long term care services.

Public Health Governance and Improvement. Central to Washington's reform goals is the improvement of the public's health. This is reflected in the design of the uniform benefit package, the emphasis on preventive interventions and in many other areas. But none is more critical than the financial and analytic commitment in the legislation to 1) provide $25 million

for targeted as well as general infrastructure improvements in the system of state and local health departments, and 2) the requirement for a detailed plan and budget for public health improvement over the course of the reform effort. This effort will include not only specific standards for the core functions of public health, but a determination of the specific percentage of overall health spending that must be dedicated to public health efforts.

Increased Tax Revenue. Our legislation provides gradual increases in state revenues through the end of the decade for expansions in public subsidies, for establishing needed regulatory mechanisms and for modest improvements in our public health system. This is accomplished by increasing taxes on cigarettes, most beer, spirituous liquor, HMO and health care service contractor payments, and most hospital revenues. The cigarette tax is 20 cents/pack in 1993, graduating to 41 cents in 1997. The tax on beer is one cent per six pack now, and 9 cents in 1998. The hospital tax is .75% now and 1.5% in 1996. The HMO and HCSC tax is 2%.

CONCLUDING REMARKS

The Washington Health Services Act of 1993 is the most recent and most comprehensive expression of no less than 20 years of effort to reform our state's health care system. We have learned that the system is hopelessly wasteful, complex, expensive and resistant to change.

The reform is an effort to update the government's role in assuring the health of its citizens by providing a system of public regulation and private market incentives to guarantee access, contain costs and promote public health.

Under the plan, individuals must obtain a minimum package of health insurance through any plan meeting a comprehensive set of public protection and cost control oriented requirements. The minimum package must be offered at no more than a maximum premium, to be determined by the state. Over time, this maximum may increase at a rate no greater than that of growth in personal income.

While there are no specific penalties for failing to meet the individual coverage requirement, several aids are provided. These include a mandate that employers provide no less than 50% of the premium of the lowest priced plan for their employees and their dependents. In addition, public subsidies are provided to reduce by some 300,000 the number of uninsured persons.

Supplemental benefits are available from certified health plans and may include any service or level of service not covered in the uniform benefit package.

The plan will limit the growth in public and private health spending through: a) managed competition among competing health plans, b) the requirement that all coverage be offered through managed care arrangements, c) the imposition of a premium cap on the uniform benefit package, d) rate regulation on supplemental benefits, e) consolidated public purchasing, f) reduced cost shifting and g) emphasis on public health and preventive services.

The Washington plan will require extensive federal waivers and exemptions from acts of Congress. Perhaps the most significant is the exemption required from the Employee Retirement Income Security Act (ERISA). In the absence of such action, the legislation directs a report on changes in state law needed to implement a residency based health care system.

Congressional action on the ERISA request or alternative action to remove health insurance from the employment relationship entirely will provide a clear opportunity to debate the merits of employer or government sponsorship of health insurance coverage. It will help Americans determine the extent to which access to affordable health services is a public good to be protected by the government, or a private prerogative which should continue to be distributed primarily as compensation for work.

Thank you for your time and attention.

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Chairman STARK. Dr. Sybinsky.

STATEMENT OF PETER A. SYBINSKY, PH.D., DEPUTY DIRECTOR FOR HEALTH RESOURCES, HAWAII STATE DEPARTMENT OF HEALTH

Mr. SYBINSKY. Thank you, Chairman Stark and members of the committee on health. Aloha. I bid you welcome on behalf of our Governor, John Waihee, and director of health, John Lewin, and thank you for the opportunity to present our health care system to the committee.

Hawaii presents the Nation's only existing health care system with a universal guarantee of access to high-quality health care and actual coverage at an approximate level of 98 percent. Our system delivers high-quality care at low cost despite our high cost of living.

The key to our success is our State's long-standing commitment to ensuring that basic health care is available to all our people. Our State has a mandated employer benefit program, the only one of its kind in the Nation, thanks to an ERISA exemption passed by Congress in 1983, a Medicaid program which reflects our people's high commitment to those in need, and coverage to those left in the gap between other programs through our State Health Insurance Program, which if I might thank Representative McDermott again, basic health was a real model for us, and they helped us out immensely in getting our program started.

The keystone of Hawaii's system rests in the Prepaid Health Care Act adopted in 1974 in a time of moderate unemployment. The Prepaid Health Care Law is the Nation's first and only employer mandate. Our system is an "everybody plays" system.

It is a simple employer mandate. Employers are required to provide health insurance to their employees; costs are shared between the employer and the employee. The employee may pay up to 1.5 percent of their monthly wages up to half the premium cost. The employer pays the balance, and dependent coverage is optional.

With only a few exceptions, any employee who works more than half time is covered by prepaid health care. Because the program is administered in conjunction with temporary disability and workers compensation in our State's Department of Labor and Industrial Relations no large State bureaucracy was created to administer State health care.

A Premium Supplementation Fund is to assist small employers, and the fund, I might add, has had minimal use over 18 years of the program. Administrative and legal sanctions are available for use when employers do not provide the mandated coverage.

Prepaid Health Care has been successful in bringing about coverage without negatively affecting business. We have included data in our long testimony that shows employment, startup of new businesses and other indicators of business health have not been negatively impacted by the law, and we are a small business State.

The act has also set the base for voluntary community rating by our State's major nonprofit insurers and thus kept health insurance rates fair and equitable for small business.

In addition, the effects of Prepaid Health Care are evident on access. In 1971, a survey showed those without hospital insurance

numbered almost 12 percent of our population and those without medical coverage 17 percent of the population. Implementation of Prepaid Health Care brought that down to about 5 percent by 1988.

While the act still serves us well, we would benefit from the ability to change elements of the system which need updating. Such areas as coverage of dependents of workers, cost-share change between the employer and the employees, particularly with respect to higher-income employees, benefits and various administrative/reporting requirements have been mentioned by various parties as possibilities for amending the act.

Currently, Congress is considering changing our exemption. We look forward to possibilities inherent in increased flexibility but are concerned with any language which might end our program, period, before it would be superseded by an effective operating national program. We would look forward to close coordination with Congress in this regard.

We have built upon Prepaid Health Care with Medicaid expansions and a stand-alone gap group program, our SHIP. And, Mr. Chairman, I might note that this was a commitment by the people of our State for extra expenditures to pick up the gap group, the people in the gap.

After 3 years of experience with using insurance for the gap group, the State is applying for an 1156 Medicaid demonstration waiver to combine SHIP, AFDC and our general assistance Medicaid population into a new managed care program, Health QUEST. We are optimistic Health QUEST, with benefits equivalent to those under the Prepaid Health Care Act, will move us into the single system of coverage for all in our State as envisioned by our health reform.

With respect to cost controls, while our system does have a strict certificate of need program, which has been effective in containing some costs, we feel the greatest cost containment feature of our system has been our commitment to universal access.

Let me explain: Historically, Hawaii's doctors have always emphasized outpatient care instead of hospitalization. Our universal access to coverage makes it possible for most people living in Hawaii to finance this care. Today, the health indicators show the results of this commitment.

As noted in a recent article to the Journal of American Medical Association, which I have attached, Hawaii has low infant mortality and low rates of premature death due to chronic diseases such as heart disease and cancer and uses less expensive outpatient care more. Early detection of potentially life-threatening conditions results in low premature mortality and morbidity.

Basically, this shows that our people are healthier because they have access to a doctor. This shows up in the cost picture as lower costs.

Recent analysis suggests our cost for health care as a share of our domestic product is closer to those of Canada, Germany, France and Japan than to the rest of the United States. And I want to note these nations have all made a commitment to universal access. Despite our high cost of living, we still have health care in our State that is less expensive.

We believe that this approach, which emphasizes a competitive system and early access to care, really will be a solution for the Nation as well as for ourselves and look at the overall approach of working with the Federal Government, the other States and the people in the United States, to enact the kind of Federal standards that will put this system in place.

Thank you very much.

Chairman STARK. Thank you.

[The prepared statement and attachments follow:]

TESTIMONY OF PETER A. SYBINSKY
HAWAII STATE DEPARTMENT OF HEALTH

Thank you for the opportunity to contribute to national health policy development by outlining Hawaii's health care reforms. We appreciate the opportunity and recognition you have given by inviting us here today.

Hawaii is often thought of as a tropical paradise. What isn't known is the fact that we have one of the best basic health systems in the nation. Our system delivers high-quality care for low cost, despite our high cost of living. While we emphasize early intervention and outpatient treatment, Hawaii enjoys high-tech tertiary care programs as advanced as any state or nation. The key to our success is our state's longstanding commitment to ensuring that basic health care is available to all our people -- our system offers access to coverage to all and in fact has covered about 98% of our people. Another cornerstone is Hawaii's innovative health care community which experimented with short hospital stays, outpatient surgery, and preventive health programs some time before they became the norm on the mainland United States.

Our state has a mandated employer benefits program, the only one of its kind in the nation, a Medicaid program which reflects our people's high commitment to those in need, and coverage to those left in the gap between these other programs through our new State Health Insurance Program (SHIP). We don't offer these programs as panaceas for the national crisis of the uninsured. But, they <u>are</u> applicable to the national debate on health care, and we are glad to offer our contribution at this forum. Together we can contribute to national policy in health care.

<u>HAWAII PREPAID HEALTH CARE ACT</u>

Let's start by exploring a few basics about the Hawaii system. The keystone of Hawaii's system rest in the Prepaid Health Care Act. Adopted in 1974 in a time of moderate unemployment this measure was effected after six years of study and policy development.

The Prepaid Health Care Law is the nation's first and only employer mandate. Employers are required to provide health insurance to their employees. Costs are shared. The employee may pay up to 1.5% of monthly wages, up to half the premium cost. The employer pays the balance. Dependent coverage is optional. Under the law, employers may provide benefits through self-insurance as long as those basic services are provided. There are coverage alternatives, a fee-for-service plan and a health maintenance plan. The fee-for-service plan -- most used in Hawaii -- provides a good package of diagnostic and treatment services, using co-payments to reduce over utilization. The HMO (health maintenance organization) plan provides a generous package of benefits.

Basically any employee who works over 20 hours a week is covered by Prepaid Health Care. Because the program is administered in conjunction with temporary disability and workers' compensation insurance in our State's Department of Labor and Industrial Relations, no large state bureaucracy was created to administer Prepaid Health Care. A Premium Supplementation Fund assists small employers who cannot, because of economic limitations, provide the insurance, and helps employees whose employers have gone out of business or who have not provided for the insurance. This fund has had minimal use over the 18 years of the program. Administrative and legal sanctions are available for use when employers do not provide the mandated coverage.

Excluded from the provisions of the Act are government employees (who have their own alternatives for coverage), seasonal agricultural workers, real estate and insurance agents working on commission, individual proprietorship members in small family business, and government assistance program recipients.

Effects on Business:

Prepaid Health Care has been very successful in bringing about coverage without negatively affecting business. Effects on unemployment have been negligible. As can be noted (Chart 1) after an unemployment rate averaging about 7% during the 1970s, unemployment has dropped significantly in the 1980s. Thus, while enacted during a period of significant unemployment, the measure does not appear to have had a long-term negative effect upon employment -- a frequent fear of small business. In fact, over the last 19 years our unemployment rate has fallen to among the lowest in the nation.

In addition the Act does not appear to have an adverse effect on "start up" of new businesses. As exhibited in Chart 2, the State has shown a consistent growth in overall businesses since 1970. Looking at a more refined measure, the start-up and termination of unemployment insurance accounts by businesses (Chart 3), it should be noted that there is no discernable downward trend related to Prepaid Health Care. We can thus see no effect on the growth of businesses as a result of Prepaid Health Care. These figures are particularly striking for Hawaii, a small business state. About 97% of our businesses employ less than 100 and 94% have 50 or fewer employees. As you can see, our employer mandate has not had an overall negative effect on small business in Hawaii.

Effects on Access:

The effects of Prepaid Health Care is evident on access. In 1971, a survey showed that those without hospital insurance were almost 12% of our population and those without physician insurance were more than 17% of the population. Implementation of Prepaid Health Care significantly reduced those percentages. Estimates of those newly provided with health insurance range to more than 46,000. A survey done in 1970 by the Department of Health estimated that only 3.9% of Hawaii's people lacked coverage. Other people were provided better coverage. The Department of Health estimates that those figures grew with the shrinking of Medicaid during the 1980s to approximately 5% in 1987-1988.

A more complete analysis of the Act and its effects is contained in an article by Dr. John C. Lewin, Hawaii's Director of Health and myself recently featured in the Journal of American Medical Association (JAMA), "Hawaii's Employer Mandate and Its Contribution to Universal Access". We have attached (Attachment 1) the article for your Committee's use.

ERISA AND PREPAID HEALTH CARE

The Prepaid Health Care Act was passed shortly before the Federal government enacted the Employee Retirement Income Security Act (ERISA) which, among its detailed provisions, preempted state employer mandates. After long court challenges, special Federal legislation was passed in 1983 which allowed the Hawaii mandate to continue. The exemption, however, used as its base the 1974 law. Since that time, Hawaii's health care environment has changed but the state lacks the ability under the exemption to amend the Act to reflect these changes.

While the 1974 Act still serves us well, we would benefit from the ability to change elements of the system which need updating. Such areas as coverage of dependents of workers, cost-share change between employer and employees (especially with respect to higher income employees), benefits, and various administrative/reporting elements have been mentioned by various parties as possibilities for amending the Act.

Currently, Congress is considering changing our exemption. We look forward to the possibilities inherent in increased flexibility but are concerned with any language

which might end our program before it would be superseded by an effective, operating national program. We would look forward to close coordination with the Congress in this regard.

COMMUNITY RATING FOR HEALTH INSURANCE

Because our Prepaid Health Care program requires that virtually all employers must provide insurance, Hawaii's major health care insurers (HMSA and Kaiser) can maintain health insurance rates for small employers which are comparable to those enjoyed by large employers. This has happened because the two major health insurers in Hawaii (both non-profit) voluntarily use modified community rating for small businesses. By pooling the small business market in this way, rates for comparable coverage are kept well below rates for small business elsewhere in the country. This has been reflected in the data in Table 1 as well as in the attached JAMA article. This community rating spreads risk across the entire small business community and does not use practices prevalent elsewhere in the United States which try to find and sell insurance to "low risk" people, leaving the "high risks", or those without the ability to pay high rates, without insurance.

The results have been extremely positive. Small business can purchase insurance at reasonable rates. Insurance companies cut administrative costs and can market to a large pool of businesses. With the Prepaid Health Care law, this practice has provided a uniformly level field for competition in which responsible small businesses who provide health insurance are not at a competitive disadvantage relative to those who do not.

MEDICAID

Hawaii's Medicaid Program serviced 101,000 persons with a budget of about $388 million in June 1993. It provides for coverage of persons up to 62.5% of the Federal poverty level. Coverage in our Medicaid program is generous, entailing most of the optional services allowed under Title XIX. The program is administered by the State's Department of Human Services.

Hawaii provides Medicaid to both categorically needy and medically needy people. The elderly and disabled with income up to 100% of the poverty level, and children under age 6 whose family income is up to 133% of the poverty level, are covered. We opted to provide coverage for pregnant women and infants with income up to the maximum allowed by statute (185% of poverty). We also implemented the "presumptive eligibility" provision for pregnant women to encourage early prenatal care. The State also provides a General Assistance Medicaid program for indigent persons who do not otherwise quality for Federal assistance. This program is identical in benefits to the Federally matched program.

We are concerned with recent cost increases in the Medicaid program, similar to those in other states, and are currently developing a program to provide the needed high-quality services at lower costs. We shall address this new program, Hawaii Health QUEST, shortly.

STATE HEALTH INSURANCE PROGRAM

The State Health Insurance Program (SHIP) was implemented to provide insurance coverage for basic health services for the small gap group remaining between Prepaid Health Care coverage and Medicaid. This group did not consist of the entire uninsured population, but largely of persons with low incomes and no alternate coverage. This group was estimated to number about 30,000-35,000 persons, and consisted of: 1) Dependents of low-income workers, particularly children; 2) Part-time workers (less than

20 hours); 3) the unemployed; 4) some seasonal workers; and 5) Low-income commissioned sales persons.

SHIP is a partnership between government, individuals and families, and the private sector. Government subsidizes insurance premiums for those unable to pay. Insurance companies provide the coverage and the already existing health care providers deliver direct care. This is essentially the model adopted by the State of Washington in its pilot Basic Health program.

Benefits

Benefits of SHIP are heavily weighted toward preventive and primary care, with health appraisals and related tests, well baby and well child coverage and accident coverage fully covered. Twelve physician visits are allowed with a $5 co-payment during the course of the year. An individual's hospitalization, however, has been limited to 5 days. Two days is allowed for maternity care. Elective surgery, and high-cost tertiary care have been excluded. The program assumes that most members of the gap group will qualify for Medicaid after exercising "spend down" for these costly procedures. The insured's share of costs is based on a sliding fee scale where individuals pay a portion of the cost on a monthly basis and are billed directly by the insurance company.

SHIP Carriers

SHIP insurance is delivered through contracts with the State's two largest insurers -- Hawaii Medical Services Association (HMSA), which has about 56% of all health insurance sold in Hawaii and Kaiser Permanente, which has about 18%. Both have worked closely with us in implementing SHIP.

The Hawaii Medical Service Association contract covers the bulk of SHIP's subscribers with a statewide fee-for-service plan, which involves almost one-half (about 1,200) of the physicians in the State.

The Kaiser contract is limited to 3,500 subscribers on the island of Oahu. Kaiser subsidizes a portion of the costs of the coverage for their full health maintenance coverage for these people.

Program Implementation

SHIP was launched statewide on April 16, 1990. From the beginning, its objective was to eliminate the barriers and red tape which often deter the genuinely needy from getting government services.

This effort has resulted in coverage for many. As of April 1, 1993, we have an enrollment level of about 20,735 (17,575 members aboard HMSA-SHIP and 3,160 in Kaiser-SHIP). As expected, SHIP members are, in general, young (39.4% are under age 18 and 83% under 45). Outreach in rural areas appears to have been successful -- almost 42% of SHIP clientele is from the generally rural neighbor islands which make up about 25% of the State's population. Sixty-four percent (64%) of SHIP membership has family income below the Federal poverty level, with over 85% of the membership below 150% of the poverty level. Our SHIP population mirrors the population of uninsured found in the Robert Wood Johnson demonstration project and in Washington State's Basic Health Plan. It is young, healthy and a good risk for insurance. Program utilization, given our short experience, appears to be good.

State of the System:

The programs outlined in this testimony together have brought approximately 98% of our citizens under health care coverage, at reasonable cost -- and all of our people have access to coverage. Those who choose not to use it, the chronically mentally ill, immigrants, and persons needing special cultural outreach, such as some native Hawaiian people, are very few and we are making special efforts to reach these people.

We cannot point to a perfect system. In rural areas, we, as many other states, have a shortage of primary care providers and people with coverage cannot always receive the needed services easily. Catastrophic care (in SHIP) and preventive services (in Prepaid Health Care) are limited in some coverage. Some individuals for various reasons, choose not to accept coverage available to them. And long-term care continues to be a problem we share with the rest of the United States, although our Executive Office on Aging has been making significant progress in designing some innovations in this areas of concern.

BEYOND MEDICAID AND SHIP -- HAWAII'S HEALTH QUEST

A major improvement to Hawaii's system of public coverage is embodied in Hawaii's new 1156 Demonstration Waiver application -- Hawaii Health QUEST. This proposal proposes to build on Prepaid Health Care, Medicaid, SHIP and a competitive insurance environment by developed managed competition for a good portion of Hawaii's public health care coverage. QUEST combines AFDC Medicaid, the State's General Assistance Medicaid and the SHIP to create a purchasing pool of approximately 90,000 persons. (For aged and disabled persons who make up the remainder of the Medicaid program will continue to receive the standard Hawaii Medicaid package.) For this pool, the State proposes to provide through fully capitated insurance coverage a Basic Benefits Package comparable to those benefits enjoyed by private sector workers through Prepaid Health Care. By allowing eligible carriers to compete, through the pool, for members' premium dollars, QUEST will keep costs as low as possible while at the same time providing choice to persons with public coverage. While persons currently eligible for Medicaid would not be required to assist in their insurance payments, persons with income in excess of 100% of the federal poverty level would share in the cost of their coverage through a sliding scale. Presumptive eligibility would be used for the program.

QUEST BENEFITS:

QUEST is designed to keep people healthy and would provide EPSDT (Early and Periodic Screening, Diagnosis and Treatment) package or benefits to all children, and appropriate preventive services to all adults. The benefit package includes inpatient and physician coverage with 15 days of inpatient psychiatric care and 5 days of detox. Emergency room coverage would have a $25 charge for non-emergent visits. Dental, prescriptive drug and ancillary coverage would also be part of the benefit package. Twelve psychiatric/psychologist visits a year would be part of the package. A "wrap around" mental health ,component would be used for those needing significant mental health services beyond the package.

With these benefits, delivered through insurance coverage rather than the traditional Medicaid approach, all receiving Health QUEST coverage will have the resources to enjoy good health and the motivation to manage their own package of benefits wisely. Not only will this result in a cost-effective, user friendly program, but it will provide for all in Hawaii accessibility to "Seamless" health care coverage and in the long run eliminate problems still extant with accessibility to health care services.

COSTS AND HEALTH QUEST:

Health QUEST does not provide an immediate cut in the costs of Medicaid. However, we do see the program as a solution to the rapidly increasing costs we foresee in the future. By bringing a major part of the Medicaid population under a managed care insurance mechanism with a special managed mental health wrap around to address the population with high chronic use of services, we expect major systemic improvements. Health QUEST encourages responsibility in a population whose open-ended coverage offered great opportunity for over use and still provides the same high-quality health services enjoyed by the rest of our population. Moreover, providers will receive compensation commensurate with standard reimbursements, encouraging them to serve public clientele, and not leave them to costly emergency room visits. By using both managed care and a defined benefit package in Health QUEST, we expect increased capacity for effective costs controls.

Governor John Waihee submitted the Health QUEST waiver application on April 15, 1993, and we have asked for an expedited approval process which would allow us to implement the program by January of 1994 (with the mental health "wrap around" to be implemented later in July of 1994). After Health QUEST is fully operational, we will begin to restructure the Medicaid system for our disabled population, taking into account their special needs.

We believe that Health QUEST embodies the most up-to-date methods of reforming health care and that, along with the rapidly developing efforts in other states, particularly those represented at this hearing, we will continue to contribute to the knowledge base of health care reform.

HAWAII'S EXPERIENCE AND NATIONAL HEALTH POLICY

Hawaii has a number of lessons which care be of assistance in national health care policy. Many people do know about our experience and many misconceptions exist.

MYTHS ABOUT HAWAII:

1. Hawaii's geography and climate is healthier to begin with.

    Hawaii is located between 18-23° N. Latitude. Other islands at or near the same latitudes are: Taiwan, Hainan (China), Haiti/Dominican Republic, Cuba, and, in the southern latitudes, Madagascar. None of these comparative island environments are particularly healthy, per se.

2. There's less stress in Hawaii than there is on the mainland.

    The cost of living in Hawaii in 1990 was 34% above that of the average mainland urban area. Housing costs are extremely high (the median rental cost in 1990 was $960, 240% of the mainland median; the median cost for purchase of a home in 1989 was $267,000). This leads to a high percentage of two wage earner families and concomitant family stress over economics, latch key children, etc. In Hawaii, we have our share of stress.

3. In Hawaii, people live a healthier lifestyle.

    Despite a climate that should make such a lifestyle more possible than anywhere else, that lifestyle remains an elusive goal. In a recent survey, Hawaii ranked below the national median on 4 of 7 healthy lifestyle indicators: no leisure activity; greater sedentary lifestyle; more "binge" drinking; and greater drinking and driving.

4. Because 67% of its population is Asian - Pacific Islander, which is healthier in national statistics, Hawaii's people are healthier per se.

In fact, our population is not innately healthier. When comparing on a Centers for Disease Control (CDC) index of premature mortality, the four large population groups in Hawaii (Caucasian, Japanese, Filipino and Hawaiian), Caucasians, Japanese and Filipinos have roughly the same levels of premature mortality. It does not appear in Hawaii, then, that these Asian groups differ significantly health wise from Caucasians. Hawaiians, however, have twice the rate of premature mortality than the other groups. Because of the small size of this group within the national "Asian - Pacific Islander" category, this poor status could well be missed. Because persons of Hawaiian descent make up 20% of Hawaii's people, actually this poor status negatively impacts on Hawaii's health figures.

5. Hawaii has been successful with an employer mandate because "its businesses can't move away".

While, on the surface, this argument would seem to hold, as Hawaii consists of islands 2,500 miles from the U.S. mainland, a deeper look suggests that this might be an erroneous assumption. Hawaii is 4 1/2 hours by airplane from the U.S. mainland, about the same distance as San Francisco is from New York City. It is connected by satellite and electronic media with financial centers world wide. While a business person might spend a few more hours in air travel in moving from Hawaii to another state, there are no real "barriers" to such a move. A more realistic concern is the ability of a business to move across state borders (in the event the state were to enact an employer mandate) and service its previous service area from outside the state. Obviously, the could not happen in Hawaii, but it is important to note that such a problem is not generic, but would apply only to specific businesses and business locations. While the problem could be a real one for the computer industry in New England, for example, such experience should not be generalized to the fast food industry in Oregon. For small businesses, even a relatively small distance precludes such a solution and in most of the United States distance, while not as extreme a factor as in Hawaii, does preclude such moves.

LESSONS FROM HAWAII:

Because our system provides up-to-date American health care services, uses insurance as its mechanism of financing and operates within the same legal/constitutional framework as other states, we believe our experience has real relevance to the nation's efforts to bring access to all of its people, at affordable costs. In brief, these are:

#1. Mandated employer coverage can be an effective tool for universal access -- without negative impact on business.

Hawaii's employer mandate brings large numbers of our people under the umbrella of health care coverage. While this approach could be criticized as being "anti-business," it actually is in accord with America's faith in the free enterprise system to find cost-effective solutions to complex problems. Through an employer mandate, government defines the extent of coverage and uses the competitive marketplace to provide that coverage cost effectively and efficiently. By requiring employers to cover their employees, an employer mandate avoids complex governmental bureaucracies and allows business to get the job done well.

Data and experience shows that, contrary to small business fears, our mandate has not brought about a bad business climate in Hawaii. Business

growth and employment have not been impacted by the mandate despite concerns expressed prior to our mandate's passage which mirror the same arguments we find against a national employer mandate. These fears did not, in fact, prove to be substantiated then and we do not believe they are substantiated now. Our employer mandate has leveled the playing field for all employers and has ensured a strong package of health care benefits for all.

#2. Insurance reform is vital to the success and equity of an employer mandate. What is also quite clear is that an employer mandate helps to ensure that insurance reforms are successful.

It is only fair that a mandate be accompanied by affordable insurance rates, which are possible in Hawaii through community rating, and the appropriate prohibition of exclusionary practices. Our community rating is voluntary, a likely product of the important role of our two large non-profit insurance providers in Hawaii's market. This voluntary modified community rating system works to keep our rates among the lowest in the nation. The insurers have been able to maintain this system without a specific legislative mandate because all employers must purchase coverage. Because all employers are in the risk pool, community rates are affordable. Because the insurance companies must compete, the market, not governmental controls, keeps the rates competitive. Thus, insurance reforms are necessary to the success of an employer mandate but the mandate is also likely to assist in making the insurance reforms viable for insurance companies.

#3. Primary health care works, not only to resolve health needs, but to contain health care costs.

Historically, Hawaii's doctors emphasized outpatient care instead of hospitalization. Today's modern practice patterns reflect this orientation. Our Prepaid Health Care Act and the other elements in our system make it possible for most people living in Hawaii to finance this care. Today, our health indicators show the results of primary care. As noted in our recent article in the Journal of American Medical Association, Hawaii has low infant mortality and low rates of premature death due to chronic disease such as heart disease and cancer; use hospitals less and use less expensive outpatient care more. Early detection of potentially life threatening conditions results in low premature mortality and low hospitalization. Emergency rooms are used less because people have ready access to a doctor. Our people are healthier not because of unique genetics, healthy climate or high tech medicine, but because they have access to primary care.

Bringing basic health services to all of Americans will not only help to improve their health status but should work to reduce health care costs. Far from adding to the costs of the system, it will actually make the system less expensive in the long run.

This is suggested by our systems experience. Recent analysis of Hawaii's health care costs suggests that our costs for health care as a share of Domestic Product are closer to those of Canada, Germany, France and Japan than to that of the rest of the United States. Despite Hawaii's high cost of living, health care in our State is less expensive. We have attached this article Hawaii Medical Journal, "Comparison of health expenditures in U.S. and Hawaii economies" (Attachment 2) for your committee's review.

#4. A solid package of standard benefits is a vital component of any health care reform effort.

A broad standard benefits package, emphasizing primary, outpatient, and community care, but including a comprehensive spread of benefits extending from

preventive services to inpatient and catastrophic care, is necessary to contain overall costs. Hawaii's experience supports inclusion of benefits and services that are demonstrated to be clinically and financially effective and appropriate and that collectively reduce unnecessary emergency department, inpatient, and high-technology care by design.

#5. Hawaii shows that states are important actors in affecting health care reform.

Thanks to its ERISA exemption, Hawaii, though a small state, has demonstrated that an employer mandate can be successful in reducing the numbers of uninsured. Even the small number remaining has now been reached through our SHIP. Further, the voluntary efforts of Hawaii's two major insurers have produced health care coverage at costs well below other areas of America. These efforts have set the stage for further reform in our Health QUEST program. Pending national reform, states like Hawaii can and must have flexibility from Federal statutes which limit reform efforts. Such flexibility should be found for reasonable state efforts currently impeded by ERISA, Medicaid, and other Federal statutes. While these laws do indeed serve in the whole very well, they constitute significant obstacles to sincere state efforts to implement reform.

In closing, Hawaii's experience shows that health reform can be accomplished, while still maintaining the basic strengths of America's health care system. Regardless of the approach our nation takes, ultimately, reforms must be rooted on these three principles:

1. Public health and prevention must be a priority to foster a healthier and more responsive society. Unless each one of us adopts responsible health practices, our health care needs will increase, wiping out the fruits of any cost containment efforts we may adopt;

2. Primary care, focussing on a community-based medical home for each citizen, must be the first priority and foundation of access efforts. Primary care is effective in lowering the need for more expensive care. It is vital that each of us has such a regular source of care, which will best be able to guide us through the complexities of the health care system.

3. Government doesn't need to run a health care system. Its presence in delivery of care, setting of reimbursements, or payments serves mostly to stifle the innate creativity which has made American health care the best in the world. Government does need to set and enforce rules by which a fair and equitable market place can operate.

We believe that awareness of and commitment to these principles will assure ultimate success to our health care reform endeavors. In any case, we all must move forward at both state and federal levels to achieve health care reform for America. Hawaii joins enthusiastically in this effort.

Thank you and ALOHA.

Attachments

CHART 1

UNEMPLOYMENT PERCENTAGES FOR THE U.S./HAWAII

	U.S.	HAWAII
1970	4.8	4.9
1971	5.8	6.9
1972	5.5	7.7
1973	4.8	7.2
1974	5.5	7.9
1975	8.3	8.3
1976	7.6	9.8
1977	6.9	7.3
1978	6	7.7
1979	5.8	6.3
1980	7	4.9
1981	7.5	5.4
1982	9.5	6.7
1983	9.5	6.5
1984	7.4	5.6
1985	7.1	5.6
1986	6.9	4.8
1987	6.1	3.8
1988	5.4	3.2
1989	5.2	2.6
1990	5.4	2.8
1991	6.6	2.8

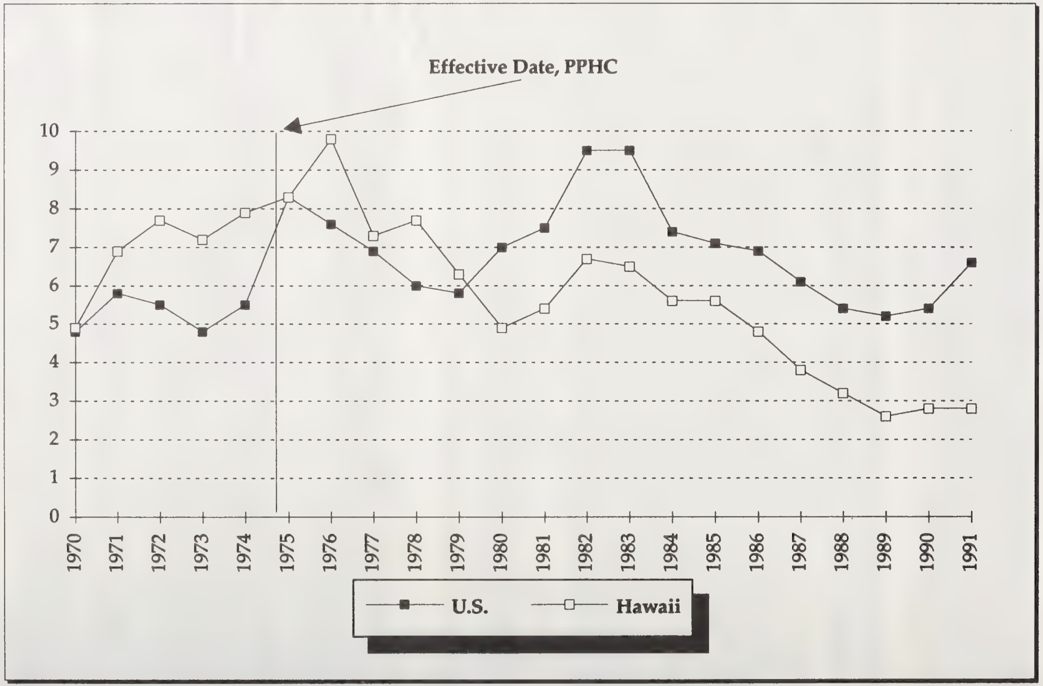
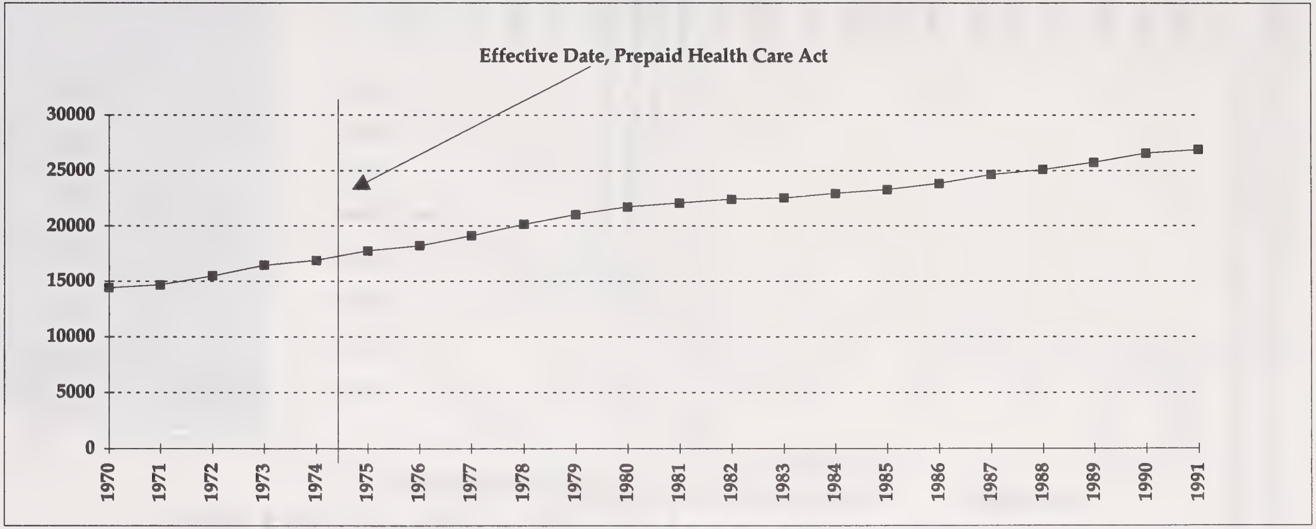


CHART 2

GROWTH IN EMPLOYERS
HAWAII 1970-1991



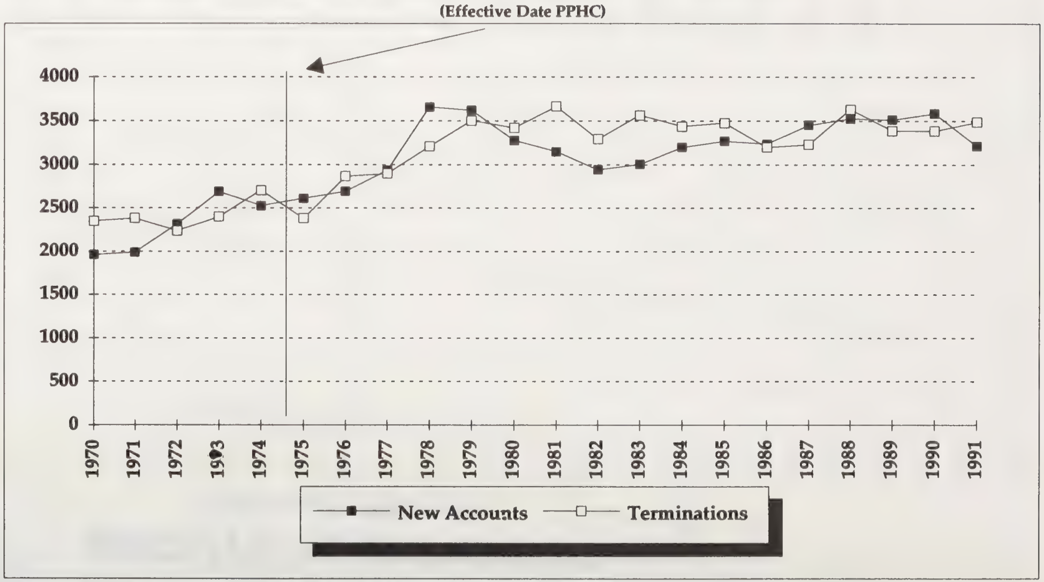
Source: Department of Labor and Industrial Relations
State of Hawaii

CHART 3

NEW EMPLOYER ACCOUNTS & TERMINATIONS

HAWAII INCOME SECURITY LAW 1970-1991

Year	New Accounts	Terminations
1970	1959	2352
1971	1989	2379
1972	2315	2240
1973	2686	2400
1974	2529	2706
1975	2610	2379
1976	2690	2864
1977	2931	2896
1978	3661	3206
1979	3621	3505
1980	3276	3420
1981	3148	3664
1982	2942	3294
1983	3001	3568
1984	3199	3437
1985	3269	3478
1986	3239	3200
1987	3453	3230
1988	3527	3633
1989	3514	3391
1990	3585	3385
1991	3214	3486



* *New Accounts - An Employer Newly Liable under the Hawaii Employment Security Law*

**Terminations - Employers who are no longer liable under the Hawaii Employment Security Law*

TABLE 1

COMPARATIVE HEALTH INSURANCE PREMIUMS

SMALL BUSINESS GROUP INSURANCE RATES*, 1990

STATE	SINGLE	FAMILY
Hawaii	94	263
New York	360	360
Kansas	564	564
Delaware	240	516
Georgia	140	340
California	141	503
Iowa	139	313
Massachusetts	217	508

* Benefits among these plans vary, although they all represent comparable health plans. Please note that no two plans are exactly the same, and plan benefits should be considered before making any direct comparisions. For example, small business plans of the Continental U.S. tend to use other factors as part of their rating critieria, such as age, sex, occupation, and location.

ATTACHMENT 1

Hawaii's Employer Mandate and Its Contribution to Universal Access

John C. Lewin, MD, Peter A. Sybinsky, PhD

Much national debate centers around national models in which an employer mandate plays an important role in providing for health care coverage for all Americans. Hawaii has had the nation's only health insurance employer mandate for almost 20 years, yet little is known nationally about the mandate itself or Hawaii's experience with it. This article describes the long-term effects of Hawaii's employer mandate on health care access and costs, and offers reflections on the potentials of national health care reform based on Hawaii's experience.

(*JAMA*. 1993;269:2538-2543)

AT LEAST since the early 1970s, employer mandates have been a part of the policy debate on how to provide cost-effective, high-quality health care coverage for all Americans. During that decade, several administrations prepared employer mandates that, for one reason or another, were eventually rejected. However, in 1974, Hawaii enacted the Prepaid Health Care Act (PPHCA), a remarkably successful law that remains the nation's only employer mandate for health care coverage. Except for a brief period in the early 1980s, employers in Hawaii have been required to cover their employees with a standard, state-established package of health care benefits. This article describes the relationship of the PPHCA to Hawaii's overall system and outlines some health costs and outcomes that the authors believe recommend this policy to other states and the nation.

HAWAII'S PPHCA

The keystone of Hawaii's health care reform efforts is its employer mandate, Chapter 393, Hawaii Revised Statutes, better known as the PPHCA. By significantly reducing the number of uninsured, this measure allowed Hawaii to implement a system of universal access to health care coverage in the late 1980s, making it the only state in the nation to offer such a guarantee to its people.

After 6 years of study and policy development, the PPHCA was adopted in 1974 to provide health care coverage for virtually all employees in the state. The PPHCA, enforced by Hawaii's Department of Labor and Industrial Relations, directs businesses to provide a prescribed standard and comprehensive benefits package for employees throughout the private sector. While not enthusiastically supported by the business community, the measure did have a great deal of support among unions and consumers. The PPHCA was supported by an environment already strong in employment-based health care coverage for comprehensive medical care through prepaid health plans. The major reasons for the PPHCA's passage were to protect the employees in the state from an erosion of health care coverage due to spiraling costs, evident even 18 years ago, and to add to the insured rolls those workers without coverage or with inadequate coverage.[1]

In this, the nation's first and only state-mandated benefits plan, costs are shared between the employer and the employee. The employee may be required to pay as much as 1.5% of monthly wages, up to half the premium cost. The employer pays the balance, but in all cases, at least 50% of the cost. Dependent coverage, while optional, has become the almost universal standard practice, the cost of which may be fully borne by the employer. Any employee who works more than 20 hours a week and makes at least 86.67 times the minimum hourly wage per month is eligible for prepaid health care.

Under the law, employers must provide as a minimum the basic services defined in Section 393-7 (Table 1). Coverage alternatives include both a fee-for-service plan and a health maintenance plan. The fee-for-service plan is the most used in Hawaii and provides a good package of diagnostic and treatment services, using copayments (usually 20%) to reduce overutilization. The health maintenance organization (HMO) model provides a generous package of benefits based on services included for a federally qualified HMO. The prescribed coverage may be purchased from any insurance provider licensed in Hawaii or provided on a self-insured basis by the employers themselves. An alternate package with fewer benefits, deductibles, and higher copayments may be substituted for the two basic plans, but then dependent coverage is required. Most employers, however, have not chosen the alternate plan.

No large state bureaucracy is needed to administer prepaid health care. A PPHCA Premium Supplementation Fund assists small employers (those with eight employees or less) who, because of economic limitations, cannot provide the required insurance, and covers employees whose employers have gone out of business or who are not in compliance with the law. During the 17 years of the program, this fund has had minimal use (a total of $85 000 has been tapped). The PPHCA is enforced by monetary penalties and a provision that the employer is responsible for all the employee's health care expenses in the event the employee is not covered by the employer, as required by law.

There are exclusions to the PPHCA. All government employees (who have their own plans or other coverage alternatives), seasonal agricultural workers (there are relatively few, and a seasonal employer must obtain a specific waiver from the state), real estate and insurance agents working on commission, family members in small family businesses, and government assistance program recipients are not covered by the PPHCA. People with coverage as a dependent under another employer's coverage are excused from being covered by their employer.

From the Department of Health, State of Hawaii, Honolulu.

Reprint requests to the Department of Health, State of Hawaii, 1250 Punchbowl St, Honolulu, HI 96813 (Dr Lewin).

Table 1.—Prepaid Health Care Benefits Based on Section 393-7, Hawaii Revised Statutes

Hospital
Inpatient (120 d)
Outpatient
Emergency department
Surgical
Physician
After care
Anesthesiologist
Medical
Necessary home, office, and hospital physician visits
Medical/surgical consultations
Medical care while hospitalized
Laboratory and radiology services necessary for diagnosis or treatment
Maternity benefits (9-mo waiting period)

Table 2.—Market Share of Health Insurance Providers in Hawaii*

Provider	Market Share, %
Hawaii Medical Service Association	56.4
Kaiser Family Foundation	18.0
Other Hawaii	8.2
Commercials	7.9
Other	9.5
Total	100.0

*Data derived from Freeman.[illegible]

Table 3.—Comparative Health Maintenance Organization Family Rates, 1992*†

Organization and State	Monthly Rate, $
Kaiser,‡ Hawaii	288
Kaiser,‡ Northern California	327
Kaiser,‡ Oregon, Washington	313
Kaiser,‡ Southern California	362
Kaiser,‡ Colorado	324
Kaiser,‡ Ohio	377
Kaiser,‡ Washington, DC	386
Group Health, Minnesota, Wisconsin	449
Harvard Community Health Plan, Massachusetts	465
Columbia Free State, Maryland	574

*Comparison subject to a number of factors including potentially different benefits and varying market situations.

†Data derived from *Consumer Reports*, August 1992.[4]

‡Kaiser Foundation Health Plan.

The prepaid health care program does not provide specifically for cost containment. However, the PPHCA has created the context required for cost containment by the health care system. The PPHCA's irreducible and broad standard benefits package, the inability under the PPHCA of insurers to reject any employed person, and the PPHCA's indirect coercion of the insurers to more effectively treat patients with chronic disease rather than reject them, and thus to use community rating, all result in a more cost-efficient system. Also, since very little bureaucracy is needed to administer the PPHCA and reporting is minimal, administrative costs created by the mandate are minimal. The healthy competition the PPHCA has fostered among the major companies for the market not only has tended to limit costs, but positions Hawaii for further marketplace competition opportunities as national health reform proceeds. Finally, the state's health planning certificate of need process administered by the State Health Planning and Development Agency has limited unnecessary construction, preventing the problems of overbuilding and overcapacity, which have driven up costs in many jurisdictions.

Overall health care costs in Hawaii remain well below the rest of the nation, but they still cause significant concern, increasing at double-digit rates for much of the 1980s. Nonetheless, a recent study comparing health care costs (including government expenditures such as Medicare and Medicaid) in Hawaii with those in the United States and other nations indicated that Hawaii's overall costs are lower than not only the rest of the nation (7.8% of gross state product compared with the US figure of 11.2% of gross domestic product), but also Canada (8.6%), Sweden (9.0%), the Netherlands (8.5%), and Germany (8.2%).[2]

ERISA AND PREPAID HEALTH CARE

The PPHCA was passed just months before the federal government passed the Employee Retirement Income Security Act (ERISA). While it focuses on pension plans, ERISA also contains language that preempts state employer health coverage mandates. Standard Oil Co, California, challenged the PPHCA in 1976 (*Standard Oil v Agsalud*), after the Hawaii state legislature passed a bill adding mental health and substance abuse coverage to the basic provisions of the 1974 PPHCA. The basis for this suit was ERISA preemption of the PPHCA. In 1981, the Supreme Court declined to review the lower court decisions and the PPHCA was overturned. It took special federal legislation in 1983 to allow the mandate to be reinstated by exempting Hawaii from the ERISA provision. The exemption was based on the 1974 law, which was enacted before the mental health and substance abuse amendment. While it has been reinstated, the PPHCA cannot be modified without congressional action.[3] Because of this limitation, the state cannot amend the PPHCA to reflect the changes in Hawaii's health care system since 1974. Amendments to the 18-year-old law would make sense in areas such as requiring mandatory coverage of dependents of workers, affording periodic and equitable cost-share adjustments between employers and employees, and modifying benefits to reflect improvements in clinical preventive services.

COMMUNITY RATING FOR HEALTH INSURANCE

Community rating spreads risk across an entire population. Commercial insurance practices often focus on trying to find and sell insurance to "low risk" businesses, leaving the "high risks," or those without the ability to pay high rates, without insurance. Without community rating, then, an insurance market is fragmented.

Because Hawaii has such a high level of persons with health care coverage due to its employer mandate, major health care insurers (the Hawaii Medical Service Association, Honolulu, and Kaiser Permanente Medical Programs, Honolulu, Hawaii) can use community rating for coverage for small employers. These rates are comparable to those enjoyed by large employers. Since Hawaii's major health insurers (both of which are nonprofit) voluntarily use modified community rating for small businesses and have such a significant market share (Table 2), rates are affordable for small business in Hawaii. Other factors, such as low inpatient utilization, contribute to the lower costs as well. As a result, fee-for-service and HMO coverage (Table 3) are well below the cost of comparable plans elsewhere in the United States.

Small businesses can purchase insurance at reasonable rates and can comply with the employer mandate without undue burden. Insurance companies cut administrative costs and can market to a large pool of businesses. Costs are low, in part because everyone must play and the young and healthy must pay into the pool along with those who are in greater need of services. The requirements of the PPHCA and responsible voluntary insurance practices have provided a uniformly level field for competition.

SYSTEM'S EFFECTS

While detailed analyses on the effects of Hawaii's system have not been undertaken, observation and preliminary data suggest that the policies established in Hawaii's system and supported by medical practice patterns in Hawaii have resulted in good health outcomes and little overall negative effects. These are evident in Hawaii's health status and its successful implementation and operation of an employer mandate and a supportive insurance system.

Effects on Health Care Coverage

The effects of an employer mandate are apparent. In 1971, 11.7% of the state's population was without hospital coverage and 17.2% was without physician coverage.[5] The PPHCA dramatically reduced those figures. Numbers of people who became insured owing to the passage of the new law were not directly

Table 4.—Reporting Units and Employment by Size of Firm, December 1990*

Size of Firm	No. of Reporting Units	% of Total	No. of Employees	% of Total
1 to 49 employees	25 768	94	173 277	38
1 to 99 employees	26 578	97	228 927	51
All employers	27 271	100	444 871	100

*Unpublished information from the Hawaii State Department of Labor and Industrial Relations.

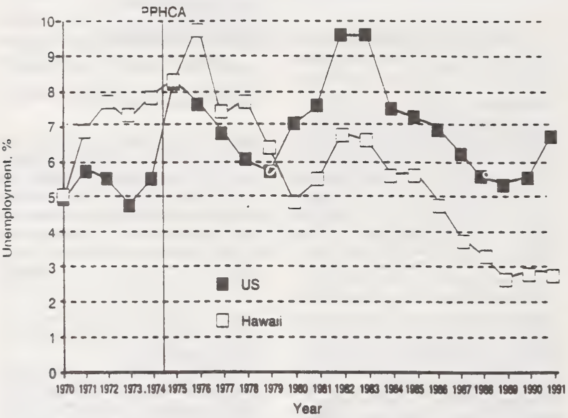


Fig 1.—Unemployment percentages for the United States and Hawaii, 1970 through 1991. PPHCA indicates effective date of the Prepaid Health Care Act. Data from unpublished information from the Hawaii State Department of Labor and Industrial Relations.

measured. One observer estimated that at least 46 000 people were immediately covered.[6] The Department of Health estimates that many more, mostly employees of small businesses, were brought on board, and a Department of Health study indicated that the overall state rate of uninsured was approximately 3.9% after the implementation of the PPHCA.[7] As the Medicaid caseload decreased in the early 1980s, the number in the gap group (those without health care coverage) grew to approximately 5% by 1987.[5]

Some of the remaining uninsured, such as professionals or people with high commission incomes, were able to purchase health services. Others, however, could not. In 1989, the Department of Health estimated the gap group in financial need or "medical indigence" to be about 3.5% of the population, about 35 000 people. Populations at risk in the gap group were the unemployed, some dependents of low-income parents, unemployed dependents, and part-time workers. While a few seasonal agricultural workers and other groups also remained outside the provisions of the PPHCA, their numbers were small. Neighbor island residents (those residing on islands other than Oahu) and immigrants were in the excluded groups in higher numbers, although they are not formally excluded from employer-based coverage.[9] With the remaining in-need population less than 5% of the population, a program of universal access was deemed feasible for the state.

This strategy took two forms. The first was expansion of Medicaid, largely by utilizing the options allowed in the various Omnibus Budget Reconciliation Act measures passed by Congress in the late 1980s and early 1990s. Medicaid was expanded to include pregnant women and infants, young children, elderly persons, and disabled persons. With these additions, and with significant growth in Hawaii/Medicaid's Aid to Families With Dependent Children caseload, Hawaii's Medicaid program grew to more than 96 000 persons by February 1993.[10]

A second option was "gap group insurance." The State Health Insurance Program (SHIP) (Chapter 431N, Hawaii Revised Statutes) was developed for those ineligible for Medicaid. This program provides a basic benefits package, rich in prevention and primary care but limited in catastrophic benefits (under the assumption that the SHIP member can use Medicaid "spend-down" for truly catastrophic events). By February 1993, the SHIP had just under 2% of the state's population enrolled, 86% of whom are under 150% of poverty. Forty percent of the SHIP clientele are children.

Together, the SHIP and Medicaid expansions have provided more than 40 000 recently uninsured people with health care coverage. The state's unemployment rate, while increasing in 1992, remains one of the lowest in the nation. The state conducted a survey on the uninsured from January through September 1991 and reported that those who identified themselves as being uninsured totaled 3.75%.[11] This remaining group may be difficult to insure owing to mental illness, severe substance abuse, or sociocultural reasons such as immigrant status. However, it is critical to point out that once these people present to a medical facility, they receive care.

Mandated health care coverage does not eliminate all barriers to health care. By and large, Hawaii has adequate health care services for its population. However, there are provider shortages in certain areas in Hawaii (four areas on Oahu and two areas on the island of Hawaii have been designated as a "medically underserved area" or "medically underserved population" by the federal government and six other areas are in the process of obtaining federal designation). Community health centers currently serve the Oahu areas and plans are under way to provide for the needs of the others.

Despite these delivery system problems, the PPHCA has been directly responsible for reducing the overall size of the gap group in Hawaii, which has permitted the state to provide cost-effectively coverage for the rest. Hawaii can claim universal access to health care coverage for all of its citizens.

Effects on Business

One of the principal objections to an employer mandate has been an alleged negative effect on business, particularly small business. Hawaii is a "small business" state. Table 4 shows that 97% of Hawaii's businesses employ fewer than 100 persons and account for 51% of the jobs in the state; 94% employ fewer than 50. We note that the available data do not demonstrate that the PPHCA has an adverse effect on business in Hawaii. In fact, some indirect indicators suggest that the effect may be positive.

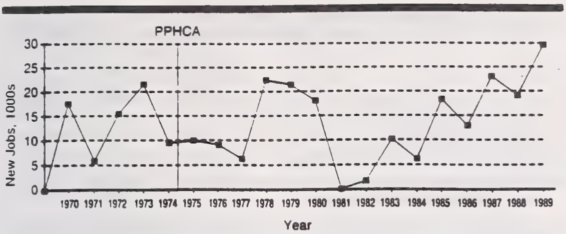


Fig 2.—Change in employment in Hawaii, 1970 through 1989. PPHCA indicates effective date of the Prepaid Health Care Act. Data from unpublished information from the Hawaii State Department of Labor and Industrial Relations.

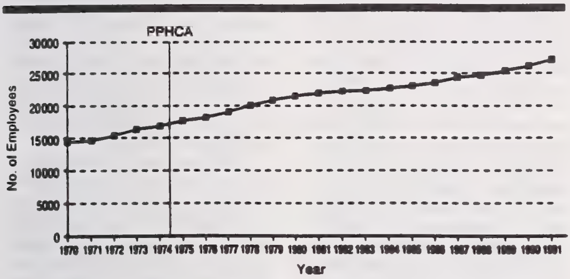


Fig 3.—Growth in employers in Hawaii, 1970 through 1991. PPHCA indicates effective date of the Prepaid Health Care Act. Data from unpublished information from the Hawaii State Department of Labor and Industrial Relations.

Table 5.—Years of Productive Life Lost (YPLL) per 100 000 due to Premature Mortality, Age Adjusted*

	Hawaii	US Population
Cancer	684	871
Heart disease	523	699
Index of YPLL, 1987	2345.3	3126.6

*Robert Worth, MD, written communication, March 1991, based on 1990 data from the Centers for Disease Control and Prevention.

Table 6.—Utilization of Community Hospitals, 1991*

	Nation	Hawaii	% of US Rate
Beds per 1000 population	3.7	2.6	70
Patient days per 1000 population	884	792	89.6
Surgery per 1000 population	87.4	52.9	60.5
Emergency departments per 1000 population	351.1	168.9	48.1

*Data derived from the *Universal Healthcare Almanac.*[16]

From a small-business standpoint, the typical argument against mandated benefits is that, as business costs increase with the burden of required health insurance, marginal businesses will fail and the growth of others will be slower. In either case, a higher than average proportion of businesses would fail and jobs would be lost. Hawaii's statistics do not bear this out. Hawaii's unemployment rate, high when the PPHCA was enacted in 1974 and throughout most of the 1970s, has shown a downward trend since 1977 (Fig 1). While unemployment did reach a high point in the year following the PPHCA's effective date, an evaluation at the time concluded that the PPHCA had no appreciable effect on business.[6] Many factors contributed to the downward unemployment trend in the two decades following the mandate, but it is clear that the PPHCA did not have the devastating economic effect predicted. In fact, viewing job creation as another indicator, Fig 2 shows that in all but 1 year since the PPHCA's effective date more jobs have been created than have been lost. Throughout this period, Hawaii has enjoyed a general growth in employers (Fig 3) and in jobs. In 1990, it was third highest in the nation in the per capita start-up of new businesses and about average with respect to business failures.[12]

One can actually argue that the employer mandate has been good for small businesses. Because its provisions set the basis for the continued voluntary community rating by Hawaii's major insurers, costs of health insurance for Hawaii's small businesses are relatively low. And, unlike other states, since all small businesses are part of the insurance pool, small businesses covering their workers are not paying for the uncompensated care costs of the small employers who don't. Finally, the PPHCA Premium Supplementation Fund rarely has been used. This would suggest that little negative impact has been felt by small businesses eligible for the supplement.

Effects on Health Status

Considering that health outcomes ought to be the key objective of a health care system, Hawaii fares very well, if not the best of all states, in terms of longevity, low infant mortality, and very low premature morbidity and mortality rates for cardiovascular and pulmonary disease and cancer.[13] Two recent national analyses of the comparative health status of all 50 states, one by Northwest Life Insurance Company, Milwaukee, Wis,[14] and another by the American Public Health Association, Washington, DC,[15] have rated Hawaii first among all states. We believe a considerable amount of this success is attributable to direct and indirect effects of Hawaii's employer mandate over the past two decades. Historically, Hawaii's physicians and agricultural plantations emphasized outpatient care over hospitalization, an orientation that continues to the present in Hawaii's medical practice patterns. While no study of health status was undertaken over the effective period of the PPHCA, data available now support our contention.

The state's continued emphasis on ensuring access to primary care for nearly all its citizens has been a major factor in better health outcomes and improved health status for Hawaii's people. This is true despite risk populations and risk factors consistent with other urban and rural areas of the nation. On an age-adjusted basis, Hawaii has many fewer years of productive life lost owing to premature mortality due to cancer, heart disease, and overall causes (Table 5). Early access to primary care also shows up in health utilization statistics. Table 6 shows that Hawaii has 70% of the national rate of acute hospital beds per 1000 population, 90% of the national average for acute hospital utilization, 61% of the national average for surgeries, and 48% of the national rate of emer-

Table 7.—Years of Productive Life Lost due to All Causes, 1990*†

By Ethnicity	Rate per 100 000 Population
Caucasians	4894
Japanese	6025
Filipinos	5689
Hawaiians	10 297

*Age adjusted.
†Robert Worth, MD, written communication, March 1991, based on data from the Centers for Disease Control and Prevention.

Table 8.—Health Risk Behaviors for Hawaii and 45 States, 1990*

	% of Population	
Risk Behavior	Hawaii	Median of 45 States
No leisure activity	31.6	28.7
Sedentary life-style	62.4	58.5
Smoking	21.1	22.7
Overweight	17.7	22.7
Binge alcohol	19.4	15.2
Drink and drive	3.9	2.9
No seat belt	4.9	25.9

*Data derived from Siegel et al.[17]

Table 9.—Comparison of Satisfaction With Health Care System in Hawaii and the Rest of the United States*

	Hawaii		
Base	Hawaii's System, % (n=1000)	Nation's System, % (n=1000)	Total US, % (n=2000)
"It works as well as can be expected" or "It works fairly well, but minor changes are needed."	76	55	40
"It works badly and major changes are needed" or "It works so badly that an entirely different system is needed."	18	39	57
Not sure/refused.	6	*	3

*Data derived from the Hawaii Health Care Survey.[19]

gency department utilization. There is no rationing, and Hawaii has the same commitment to tertiary care and new technologies as other states. We believe the economies of lower inpatient utilization are a major source of Hawaii's lower costs.

Other hypotheses for the state's better outcomes abound. Because of a high proportion of Asian–Pacific Islanders in its population, Hawaii is purported to have a healthier "genetic stock"; in national data, Asian–Pacific Islanders appear to have better health status in all states. If this is so, the Asian–Pacific Islanders in Hawaii's population presumably would have better health status than Caucasians. However, analysis of recent data belies this hypothesis. As can been seen in Table 7, when age-adjusted populations of Japanese, Filipinos, Caucasians, and Hawaiians are compared (together these four groups make up 85% of Hawaii's population), Japanese, Filipinos, and Caucasians have similar status in terms of years of productive life lost per 100 000 people, with Caucasians coming out the best overall. The only group at variance from this profile are the native Hawaiians, representing 20% of the population, but with about twice the rate of productive years lost. These data suggest no major ethnic component to Hawaii's improved health status, and reveal that the category of Asian–Pacific Islander used in reporting national health statistics appears to mask the poor health status of Pacific Island peoples in Hawaii and might also be hidden in national statistics as well.

Another frequently stated hypothesis about Hawaii's good outcomes and lower health costs presumes that superior life-style choices and climate are responsible. However, Hawaii's data are not particularly noteworthy in this regard. Compared with the other states surveyed by the Centers for Disease Control and Prevention, Hawaii actually ranks above the median for 45 states on four of seven indications of "unhealthy" life-style: lack of leisure-time activity, sedentary lifestyle, binge alcohol drinking, and percentage of population drinking and driving (Table 8). The incidence of essential hypertension and hypercholesterolemia is higher than national averages. Life-style factors reflect Hawaii as an above-average state perhaps, but certainly do not in themselves explain Hawaii's excellent health mortality outcomes and lower costs.

While Hawaii's warm climate reduces health care expenses due to cold weather (eg, pneumonia, falls from slipping on ice), the state experiences more drowning, bodysurfing and ocean injuries, and skin cancers. Because Hawaii is a gateway for immigration from the Asia/Pacific region, it has the second highest rate of tuberculosis in the nation, and ranks among the top 10 states in per capita incidence of human immunodeficiency virus contraction.[18] It also has been calculated by the Hawaii State Department of Health to have the highest rate of hepatitis B in the nation and a high rate of Hansen's disease.

Access to basic health care appears to have been a key factor in improving the health status of Hawaii's people through the reduction of unnecessary inpatient and emergency department care. However, this analysis needs further documentation and investigation.

PUBLIC PERCEPTION OF EFFECTS

Public support for Hawaii's system is strong in the state. A recent poll conducted by Louis Harris and Associates, New York, NY, and sponsored by the Kaiser Family Foundation and the Queen Emma Foundation shows this.[19] The study was designed to be comparable to a national study conducted by the Kaiser Family Foundation and the Commonwealth Fund in late 1991. The Harris poll provides a good comparative base for the perceptions of Hawaii respondents with those of the rest of the nation. In that survey, 76% of the respondents felt that Hawaii's system "works as well as can be expected" or "fairly well, but minor changes are needed," with 55% of Hawaii respondents indicating similar confidence in the nation's system. Nationally, only 40% of the respondents had a similar opinion. On the other hand, 18% of Hawaii's respondents felt the system worked badly and needed major changes or an entirely new system, as opposed to 57% of the national sample (Table 9).

Citizen confidence in Hawaii's state-based system is also evident when the respondents are asked about their choices of who should lead the health care reform effort. While 62% of the national sample looked to the federal government to lead health reform, only 48% of the people polled in Hawaii picked the federal government to lead. In Hawaii's case, 43% chose the state to lead, compared with only 30% of the national sample.[19] Thus, while Hawaii recognizes the need for a 50-state system for true health care reform, the response of its citizens implies confidence in the directions and responsibility taken locally.

LESSONS FROM HAWAII'S EXPERIENCE

Hawaii's experience with an employer mandate injects several lessons into the national debate. As the only state with an employer mandate, Hawaii runs the risk of being termed "an outlier" or an anomaly owing to factors as diverse as its geographic location or the ethnic makeup of its people. While unique in many ways, Hawaii's overall health care system, hospital costs, provider salaries, and standards of care are not atypical among states. However, the state's commitment to universal access, community insurance rating, and primary and preventive care have paid unexpected cost-containment dividends in addition to the expected social rewards. This experience does deserve consideration by national and state policymakers.

Hawaii's experience suggests much from which the nation can benefit:

1. An employer mandate can be a pow-

erfully effective means of increasing access, without a devastating impact on business. Several hypothetical studies based on projections and a limited number of variables have predicted that an employer mandate would result in a loss of jobs or a business slowdown.[20,21] Hawaii's actual experience suggests the opposite: Insurance rates are lower, there's a sizable reduction in uncompensated care, insurance practices are more equitable, and all employers are included. We do not believe an overall negative effect on either business or employment has occurred in Hawaii owing to the employer mandate.

2. Fair insurance practices are essential for and are supported by an employer mandate. By providing a base for community rating, Hawaii's employer mandate provided a base for the generally fair system of insurance coverage in the state. Because all employers are in the risk pool, community rates are affordable, and insurance is transportable. This provides the strong argument from Hawaii's perspective for a simple and clear, "everybody plays" mandate.

3. A broad standard benefits package, emphasizing primary, outpatient, and community care, but including a comprehensive spread of benefits extending from preventive services to inpatient and catastrophic care, is necessary to contain overall costs. Hawaii's experience supports inclusion of benefits and services that are demonstrated to be clinically and financially effective and appropriate and that collectively reduce unnecessary emergency department, inpatient, and high-technology care by design. We believe that some mental health, substance abuse, dental, and pharmaceutical drug coverage must be included in a cost-effective, minimum-benefits package to promote cost containment through more successful primary and noninstitutional care.

4. Universal access is in itself a cost-containment strategy. Because virtually all of Hawaii's people have access to primary care coverage through the employer mandate and the state programs it has made possible, utilization of high-cost services in Hawaii is well below the rest of the nation. This leads to the lower health care costs, comparatively low small-business insurance rates, and a lower portion of gross domestic product spent on health care when the state is compared with the nation.[2] By allowing free access to primary care, a national or state health policy could decrease the use of expensive modes of care and thus decrease health costs. Universal access, then, has been our best cost-cutting tool.

5. States can be successful in health care reform. Even though a "small business" state, Hawaii has demonstrated that states can implement comprehensive health reforms when given flexibility by the federal government to design and implement these reforms. Hawaii's ERISA exemption was crucial in this reform process. Recent federal court decisions are citing ERISA to limit an ever-increasing number of incremental state-mediated reforms. For example, in New Jersey, the decision in *United Wire, Metal, and Machine Health and Welfare Fund v Morristown Memorial Hospital* overturned that state's long operating uncompensated care fund. It would seem prudent public policy to allow for careful and deliberate state experimentation through ERISA exemptions or waivers in the event the needed national reform does not happen right away.

CONCLUSION

While health care reform has increased significantly in importance to the American public in recent years, no specific health reform strategy has yet found general support by a majority of American people.[19] Hawaii offers positive and nonhypothetical experience with the nation's only employer mandate, coupled with the advantages of community insurance rating and an emphasis on primary and preventive care. Our state demonstrates and validates that this approach is a viable one for serious consideration in health care reform not only by other states, but by the nation itself as the Clinton administration and the Congress proceed to grapple with the issues involved.

The authors wish to thank the following individuals for their invaluable help in making this article possible: Mario Ramil, Orlando Wannabe, Frederick Pang, and Tomio Anzai, the Department of Labor and Industrial Relations, State of Hawaii; Cliff Cisco, Hawaii Medical Services Association; Barbara Hastings, Robert Worth, MD, Anthony Ching, Kathleen Kondo, Claire Adachi, and Annette Perumbala, the Department of Health, State of Hawaii; and Joshua Agsalud, EdD, Office of the Governor, State of Hawaii.

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ATTACHMENT 2

. . . proof that we're healthier?

Comparison of health expenditures in U.S. and Hawaii economies

Richard V Stenson MHA MBA FACHE FACMGA

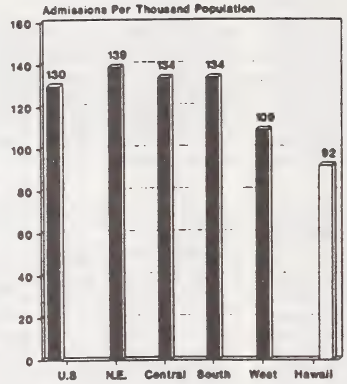
The author uses published statistical and economic data to demonstrate that Hawaii's health care costs, as a percent of gross product, are significantly below the U.S. average, perhaps as low as 8.1% of Gross State Product (GSP).

Introduction

Although a great deal has been written about the growing portion of the Gross National Product (GNP) being expended on medical services, there has been no comparative data published previously on the share of Hawaii's Gross State Product (GSP) consumed by health care expenditures. Further, since health care costs have been rising steadily in both Hawaii and the U.S., business leaders and government authorities here may well assume that Hawaii's costs are comparable to those on the mainland U.S.

Hawaii's health service providers believe that since the State is among the lowest in rates of hospital admissions and outpatient visits in the country (Graphs 1 & 2)[1], has far fewer hospital beds per population (Graph 3)[2], and hospital expenses generally below those of comparable, high cost-of-living states (eg California, New York, and Alaska[3]), the percent of Hawaii's GSP used to provide medical goods and services is presumed to be less than that for the U.S. as a whole.

GRAPH 1.
SHORT-STAY HOSPITAL ADMISSIONS (1987)

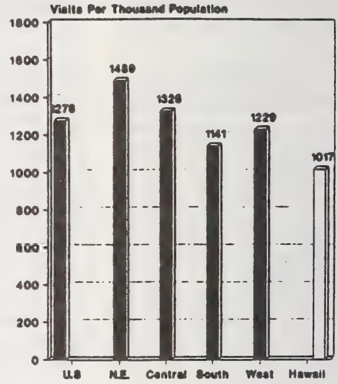


Source-1990 Statistical Abstract of U.S.

Methods

This paper compares the major medical economic data ele-

GRAPH 2.
HOSPITAL OUT-PATIENT VISITS (1987)



Source-1990 Statistical Abstract of U.S.

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(Continued) ➤

COMPARISON *(Continued from page 10)*

ments in the U.S. and Hawaii. The sources of information are existing published data, primarily the Hawaii Department of Business, Economic Development & Tourism's (DBED) annual *Data Book* and the Health Insurance Association of America's (HIAA) annual *Source Book of Health Insurance Data*.

The HIAA data are produced largely from the federal Health Care Financing Administration's (HCFA) tabulation of Personal Health Care Expenditures (PHCE), whereas the State's DBED reports use the methodology of the U.S. Commerce Department's Personal Consumption Expenditures (PCE) — Medical Care component, as reported in National Income and Product Accounts (NIPA). There are minor differences in accounting methodologies used by HCFA and Commerce. As a result, the Commerce NIPA and related DBED figures have been somewhat lower relative to the HCFA tabulations. (HCFA and Commerce are working to resolve this problem in the next 2 years.) If this difference in methodologies is left unadjusted, the Hawaii data appears even more favorable (lower) than presented in this paper.

The following data and graphs compensate for this built-in understatement by raising DBED reported Hawaii figures by the same ratio of the difference between NIPA and HCFA medical care consumption accounts for each of the years cited (eg the effect for 1988 was to increase Hawaii's percent of GSP for medical care from 7.5% to 8.1%). These interpolations are based on the U.S. Department of Commerce's *Personal Consumption Expenditures Methodology Papers: U.S. National Income and Product Accounts*, June 1990, and issues of the U.S. Department of Commerce's periodical *Survey of Current Business*. Where minor data elements for Hawaii are unavailable, ie, net cost of health insurance, public health activities, research and construction (combined total less than 12% of total health expenditures), they are interpolated at national norms for those years.

TABLE 1

1988 HEALTH EXPENDITURES BY TYPE (Millions)

Type of Expenditure	U.S.	Hawaii*
Personal Health Care***	$478,000	$1552
Program Administration and Net Cost of Private Health Insurance[a]	26,000	85
Government Public Health Activities[a]	17,000	51
Total Services and Supplies	521,000	1,688
Research and Construction[7]	19,000	64
Total Health Expenditures	$540,000	$1,752

* The Hawaii figures have been proportionally raised for an equitable comparison with national accounts, as noted in the preceding discussion.

** "Personal Health Care" represents private and public spending for direct health and medical services to individuals, whether insured or not. The figure includes items such as hospital, nursing home, and home health care; physician, dentist, and other professional care; drugs and other medical nondurables; vision products and other medical durables; also included are nonprescribed drugs and medicines, household supplies and other items not covered by insurance.

TABLE 2

1988 U.S. AND HAWAII HEALTH EXPENDITURES (Millions) AS A PERCENT OF GROSS PRODUCT*

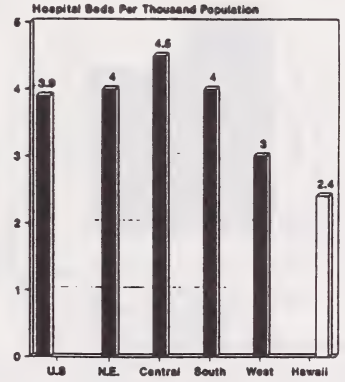
$$\frac{\text{U.S. Health Expenditures}}{\text{Gross National Product}} = \frac{\$540{,}000}{\$4{,}881{,}000} = 11.1\%$$

$$\frac{\text{Hawaii Health Expenditures}}{\text{Gross State Product}} = \frac{\$1{,}752}{\$21{,}588} = 8.1\%$$

Results

A comparison between U.S. and Hawaii health expenditures indicates that the percent of Hawaii's GSP consumed by medical goods and services was at 8.1% in 1988, versus the U.S. experience of 11.1% of GNP (Table 1, Table 2, and Graph 4). A review of data from prior years indicates this divergence began in 1983 and has increased since then (Graph 5). Graph 6 (per capita annual health expenditures in current dollars for both Hawaii and the U.S.) demonstrates that the ratio favorable to Hawaii is not simply an aberration of the rapidly expanding local economy (the GSP denominator in the ratio), but is due to a generally lower and slower rate of growth of the health care expenditures in Hawaii.

GRAPH 3.
SHORT-STAY HOSPITAL BED SUPPLY (1987)



Source-1990 Statistical Abstract of U.S.

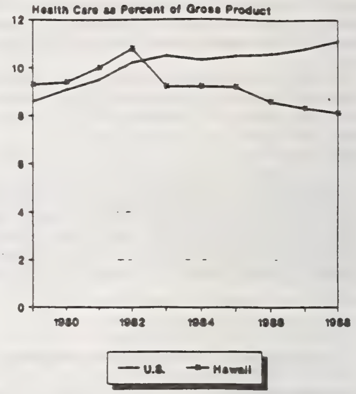
When compared to other industrialized countries with purportedly exemplary national health programs, Hawaii's health expenditures as a percentage of the economy are lower than in many. Graph 7 depicts the relative health expenditures as a percent of Gross Domestic Product (GDP = GNP less net foreign investment income), in the U.S., Canada, United Kingdom, Japan, Germany, Sweden, the Netherlands and Hawaii. Hawaii has the third lowest expenditure ratio in this comparison.

Discussion

The specific causes of this enviable cost of health care record in Hawaii have never been delineated. Many theories have been advanced to explain our favorable health status (greatest longevity in the U.S.) and lowest hospital utilization. The various factors mentioned include the mild climate, the multi-cultural population, an oligopolistic health insurance industry, a mandated workplace health insurance coverage, as well as the role of the State Health Planning and Development Agency (SHPDA), to name a few. To date, none has proven to be the primary element restricting our health service utilization and expenditures. This is worthy of further research, since the answer may be beneficial to other communities attempting to deal with soaring health costs.

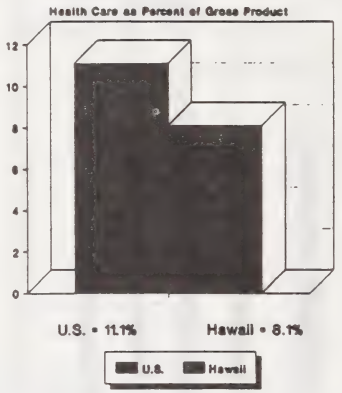
However, one wonders whether our overall health expenditures are lower, in part, because Hawaii's health providers are being paid less per unit of service than their peers in other communities with comparable high costs of doing business, as is frequently implied by anecdotal comparisons with Mainland counterparts.

GRAPH 5.
HEALTH EXPENDITURES AS % OF GNP AND GSP



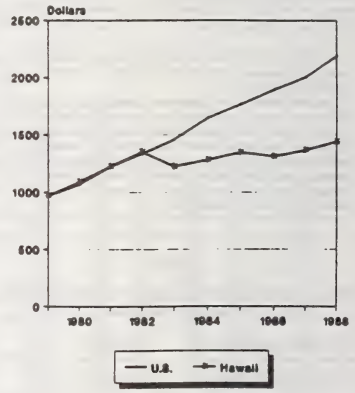
(Derived from HIAA and DBED data)

GRAPH 4.
1988 HAWAII VS. U.S. HEALTH EXPENDITURES



(Derived from HIAA and DBED data)

GRAPH 6.
PER CAPITA ANNUAL HEALTH EXPENDITURES



(Derived from HIAA and DBED data)

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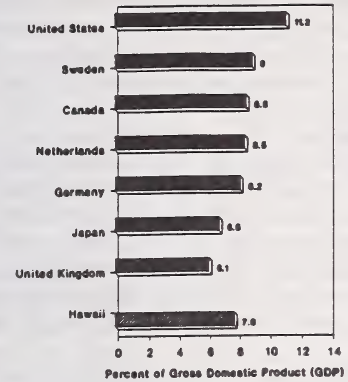
COMPARISON *(Continued from page 13)*

GRAPH 7.
HEALTH EXPENDITURES AS % OF 1987 GDP



(Derived from HIAA and DBED data)

Conclusion

Health care expenditures have been rising inexorably all across the U.S., including Hawaii. Much has already been written about the causes of this growth, eg increasing consumer demand, aging population, advances in health technologies, scarcities of professional labor and general inflation. Nevertheless, this paper demonstrates that Hawaii's health care purchasing power, relative to other costs in our economy and the U.S. as a whole, is a proven better value to the people of our community.

Perhaps the State would be best served if the efforts of our community leaders focused on a comprehensive study of why Hawaii has done so well. In this way we might learn how to maintain and improve on this successful record, and transfer our experience to other states.

LEGEND AND REFERENCES

1. *1990 Source Book of Health Insurance Data*, published by Health Insurance Association of America (HIAA), page 78, Table 5.2, lists days of short-stay hospital care per 1,000 U.S. population for 1988 as 834. The Hawaii Department of Health (DOH) *1988 Statistical Report*, page 94, Table 7 lists average statewide acute care daily census (including Tripler Army Medical Center [TAMC]) as 2,073. The Hawaii Department of Business, Economic Development & Tourism's (DBED) *1990 Data Book*, page 14, Table 3 lists a 1988 *de facto* state population of 1,216,700. When 2,073 is multiplied by 366 days (a leap year) and divided by the *de facto* population of 1,216,700, Hawaii had 624 days of acute care hospitalization per thousand population for 1988.

Graphs 1 and 2 use data published in the *1990 Statistical Abstract of the U.S.* 1987 short-term hospital admissions and out-patient visits (page 106) are divided by 1987 regional population figures (page 20) to create Graphs 1 and 2, respectively.

2. The DBED *1990 Data Book*, page 618, Table 719 ranks Hawaii 49th in hospital beds per population. The HIAA *1990 Source Book of Health Insurance Data*, page 64, Table 4.9 lists total U.S. acute hospital beds as 946,697 for 1988. The U.S. Department of Commerce, Bureau of Census, *1990 Statistical Abstract of the U.S.*, page 7, Table 2 lists the 1988 U.S. population as 246,329,000. Therefore, U.S. acute hospital bed per thousand population were 3.84. Whereas the DOH *1988 Statistical Report*, page 90, Table 1 lists Hawaii statewide acute hospital bed capacity (including TAMC) for 1988 at 2,855. And, the DBED *1990 Data Book*, page 14, Table 3 lists the 1988 *de facto* state population as 1,216,700. Therefore, the Hawaii acute hospital beds per thousand population were 2.35. Or, Hawaii was only 61% of the U.S. ratio of hospital beds to population.

Graph 3 uses data published in the *1990 Statistical Abstract of the U.S.* 1987 short-term beds (page 106) are divided by 1987 regional population figures (page 20).

3. The HIAA *1990 Source Book Of Health Insurance Data*, page 64, Table 4.9 lists 1988 average costs per hospital stay (expenses) for each state. Hawaii average hospital cost per hospital stay was $4,651. Alaska was $5,616 per stay. New York was $5,070 per stay. California was $5,061. Nine states had higher average hospital stay costs than Hawaii.
4. U.S. value from HIAA *1990 Source Book of Health Insurance Data*, page 56, Table 4.1. Hawaii value from DBED *1990 Data Book*, page 349, Table 388 "1988 Personal Consumption Expenditures, Resident Population, Medical Care: $1,441,000,000."
5. 1988 U.S. value for Program Administration and Net Cost of Private Health Insurance from HIAA *1990 Source Book of Health Insurance Data*, page 56, Table 4.1. Hawaii data unavailable, but estimated at same proportion (5.5%) of Personal Health Care as U.S. expenditures.
6. 1988 U.S. value for Government Public Health Activities from HIAA *1990 Source Book of Health Insurance Data*, page 56, Table 4.1. Hawaii data unavailable, but estimated at same proportion (3.3%) of Personal Health Care as U.S. expenditures.
7. 1988 U.S. value for Research and Construction from HIAA *1990 Source Book of Health Insurance Data*, page 56, Table 4.1. Hawaii data unavailable, but estimated at same proportion (4.1%) of Personal Health Care as U.S. expenditures.
8. 1988 Gross National Product from HIAA *1990 Source Book of Health Insurance Data*, page 57, Table 4.2. Gross State Product from DBED *1990 Data Book*, page 346, Table 385.

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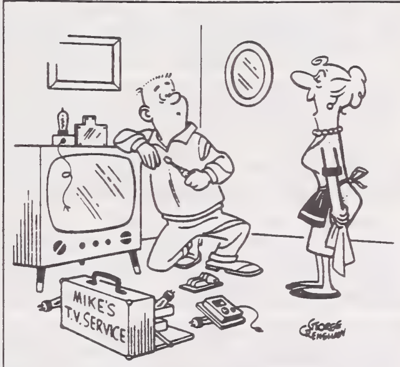

"IT STOPPED PLAYING RIGHT DURING GENERAL HOSPITAL. WILL MY BLUE SHIELD PAY FOR IT?"

Chairman STARK. Mr. Cook.

STATEMENT OF DOUGLAS M. COOK, DIRECTOR, FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Mr. COOK. Thank you, Mr. Chairman.

Your former colleague, our Governor, former Senator Chiles, asked me to extend his thanks and gratitude to you for allowing us to appear before this committee. He asked me to tell you he misses you, but he doesn't miss the job that you are doing. But he does suggest to you we need your help.

I came to this job about a year ago from a former job as the budget director of the State and prior to that serving on the United States Senate Budget Committee. What I have seen in the past 2 to 2½ years in our States is a drastic and dramatic devastation in our public programs and in our economies led by the high cost of health care. There has been a drastic and dramatic reordering of State priorities, deep cuts made in our education budget and our budgets which protect our children and protect our citizens and protect our environment.

The reason the States are here today, more than our great sense of the need to provide health care for everyone, is our acknowledgment and our knowledge that if we don't resolve the health care crisis, we cannot do anything else.

What have we done in Florida over the past couple of years to try to resolve that crisis?

First, we set a goal for universal coverage. We have learned a great deal from Pete Sybinsky and Jack Lewin and Governor Waihee from Hawaii about the need for universal coverage and the fact that unless and until you establish that goal and set that goal as a primary target, the market will not respond.

Secondly, we have adopted modified community rating because without insurance reform you cannot solve the problem.

Thirdly, we have insured guaranty issue, because no one can be denied access to health care and have us control the cost of this system or managed the system any better.

Next, we established 11 Community Health Purchasing Alliances, what we call our CHPAs. These purchasing alliances will have responsibility for improving and assuring coverage and controlling cost. These are public-private partnerships with a business sector dominating them. There are 17-member boards. The business community will have 11 of those 17 members.

We have established a program to develop and establish statewide practice parameters because, as you have seen and we have seen, we worked very hard in the Senate Budget Committee a number of years ago to reduce the cost of health care. What we have seen in the Medicare program, and as you know in envisioning a Medicare cap, is a dramatic increase in utilization both in Medicare and Medicaid to avoid the ratesetting mechanisms we have tried to establish in Congress and on the national level.

We do believe in Florida that the market can respond. We do believe that there is a system that will allow that market to respond. Obviously, that market does not exist today. I don't think anyone would argue the health care market is a true market, but it is not a true market because we lack a sticker on the window for cost and

quality. We don't know what the true cost of health care is, and we will never know what the true cost of health care is until we commit ourselves to achieve universal coverage.

As long as 37 million Americans, 2.5 million Floridians, nearly 1 in 5, between 1 in 5 and 1 in 4 Floridians is uncovered, as long as the tremendous cost of that gap group, 80 percent of which as you know are working people and their families, are transferred on to the rest of the system, none of us can establish the kind of unit costing structure that allows for a comparative cost estimate.

Our market has begun to respond to our reforms. We have 1–800 numbers established all over the State. Our physicians, who had previously viewed managed care as an insidious Communist plot, have now filled up the phone lines trying to join managed care networks.

The ultimate question before the committee, in the spirit of the Chairman's questions, are how much good can we do and how quickly can we do it.

In the spirit of the Chairman's questions, I would like to say implicit in there is the question, can the States go it alone? How far have the States gone in going it alone? Absolutely not. States have never thought, never said, never suggested that they could go it alone.

Our problem is we cannot run a deficit, and so we have been forced to make decisions due to the high cost of health care that the Federal Government has been able to avoid, that, frankly, we were able to avoid when I served with Senator Chiles in the United States Budget Committee.

The Feds must establish guidelines for cost and coverage and quality. They must also establish incentives for the States to achieve those targets and guidelines.

We must recognize implicit in Mr. Levin's questions that the national system will evolve over a number of years, but we must treat the crisis, and we must treat the hemorrhage first. Our crisis is immediate. Our crisis is real. We are doing damage as, you know, as we speak.

Look in any State health notes and on any State's calendars and there are special sessions in every State of the Union today to further cut back vital investments for the States that will ultimately restore our economy.

Our problem is we cannot afford the national health care system as it exists today. We would suggest to you—the State of Florida would suggest to you that we deal with first things first. There is a great deal of complexity in this system. There is much we don't understand, and I would say none of us understand about how to reform the health care system, but, until we cover the gap, we will never resolve this problem. Until we establish a unit costing structure, we cannot solve this problem, and we must focus on covering that gap group.

We have suggested to you what we call a Medicaid buy-in program because there is an established benefit program in place. We would suggest to you, as the Senator from Washington indicated, that when you try to establish the national benefit standard you are in for a thousand willing providers amendments, most of which

we were able to stave off in our reform effort as they were able to stave off in theirs. That is 1 year's debate in and of itself.

The thought that we can reform national health care in a year is, we would suggest, perhaps a bit more ambitious, but we can do something. We can cover the gap, and we can cover the gap now.

And if we do something about covering that gap group—we have a briefing the governor likes to give to legislators based on my old friend Jim Carville's statement that, "It is the gap, stupid." Until or unless we cover that gap, we will never solve this problem.

Finally, we would suggest to you that what we must get out of the Congress this year is some path, some surety, some confidence and some hope. We are quickly losing hope in the States. That is why we are acting so desperately. Our political consensus is dissolving. Our public consensus is dissolving. And until or unless we get some hope from Congress and the national Government, we will be in desperate shape.

Thank you very much.

Chairman STARK. Thank you.

[The prepared statement follows:]

TESTIMONY OF DOUGLAS M. COOK, DIRECTOR STATE OF FLORIDA HEALTH CARE ADMINISTRATION

Introduction

The need to fundamentally reform our nation's health care system is finally receiving the attention it deserves, due, in large part, to President Clinton's commitment to make it a priority issue in his Administration. The states are ready to be partners in the campaign to control health care costs and ensure that all Americans have access to high-quality affordable health care. States can play a vital role in the nation's health reforms by testing alternatives. To perform this role, however, the states need flexibility from certain federal statutory and regulatory constraints that prevent the full implementation of comprehensive health reforms. Florida, in particular, is willing and able to make valuable contributions because of two major health reform laws the state legislature recently enacted.

Last year, the Florida Legislature enacted the Health Care Reform Act of 1992, which contained sweeping plans for fundamentally changing the way health care is paid for and delivered in the state. The 1992 law sets a firm deadline of December, 1994 for all Floridians to have access to basic, affordable health care. This year, the state legislature enacted the Health Care and Insurance Reform Act of 1993, which builds on the 1992 law and creates community health purchasing alliances to implement a managed competition model in Florida.

The nation's health care problems are magnified in Florida. Most Floridians have insurance, but 2.5 million residents, 18.5 percent of the population, are uninsured. One-third of the uninsured are children. Florida's health reforms are designed primarily to address its "gap group"--those uninsured residents who are ineligible for Medicaid, but whose incomes are below 250 percent of the federal poverty level.

Florida's Health Reform Laws

Health Care Reform Act of 1992

The Health Care Reform Act of 1992 contains the following major features:

Florida Health Plan

- Creates the Florida Health Plan, a multi-strategy, comprehensive health plan. Provides principles and strategies the state will pursue to address issues of health care access; cost containment; quality of care; insurance reforms; and health care data collection, research, and analysis

- Requires that all Floridians have access to a basic affordable health care package by December 31, 1994

- Creates a unique public-private health care coverage and cost containment program to encourage employers to offer health benefits to their employees and health care providers and insurers to reduce health care costs

- Establishes health care coverage and cost containment targets against which the success of the public-private program will be measured

Small Business Health Insurance Reform

- Creates the Employee Health Care Access Act, requiring small employer carriers to offer standard and basic health benefit plans to employers with 3 to 25 employees

Agency for Health Care Administration

- Created the Agency for Health Care Administration, effective July 1, 1992, consolidating health care financing, purchasing, and policy making and planning, as well as health facility regulation and cost containment functions into a single agency

- Effective July 1, 1993, makes the agency responsible for Medicaid, the State Employees' Health Insurance program, the Florida HealthAccess Corporation, and the Florida Healthcare Purchasing Cooperative

Practice Parameters

- Directs the agency, in conjunction with the relevant medical associations, to guide the adoption and implementation of scientifically sound practice parameters to eliminate unwarranted variations in health care delivery

Health Promotion Program

- Establishes a comprehensive, community-based health promotion and wellness program to reduce behavioral risk factors associated with chronic diseases, injuries and accidents

Florida Health Services Corps

- Creates the Florida Health Services Corps to encourage qualified health professionals to practice in underserved locations of the state

Health Care and Insurance Reform Act of 1993

This year's law makes explicit the state's commitment to pursue market-driven health reforms. The major elements of the law include:

Community Health Purchasing Alliances (CHPAs)

- Improves the efficiency of the health care market by (1) allowing purchasers and consumers to pool their buying power; (2) promoting cost-conscious consumer choice of managed care plans; (3) rewarding providers for high quality, economical care; (4) increasing access to care for the uninsured; and (5) controlling the rate of health care inflation

- CHPA membership is available to (1) small businesses with up to 50 employees, and (2) the state, for the purpose of providing health benefits to state employees and their dependents; Medicaid recipients; and MedAccess (Medicaid Buy-In) program participants. Provides for "associate alliance members," which include large employers, to participate on the alliance boards and receive data from the alliances

- Creates one non-profit CHPA in each of the 11 health service planning districts. Each CHPA operates subject to the supervision and approval of a 17-member board of directors representative of alliance members, consumers, and government purchasers--prohibits board members from having any connection with a health care provider or insurer

- CHPAs provide member purchasing services and detailed information to their members on comparative prices, usage, outcomes, quality, and enrollee satisfaction with accountable health partnerships (AHPs)

- CHPAs must develop plans to facilitate participation by providers in the district in an AHP, with special emphasis on participation by minority physicians

- Authorizes CHPAs to issue requests for proposals from AHPs for the standard and basic plans and specialized benefits approved by the alliance board

- Provides for preferred provider networks, point-of-service products, exclusive provider organizations, health maintenance organizations (HMOs), or pure indemnity products to be offered to alliance members, if such plans are reasonably available within the CHPA's jurisdiction

- Ensures a wide choice of AHPs to state employees, including five HMOs and five preferred provider organizations

- Any employer that employs 30 or fewer employees must offer at least two AHPs or health plans to its employees and an employer that employs 31 or more employees must offer three or more AHPs or health plans to its employees

- Makes the Agency for Health Care Administration responsible for certifying the CHPAs

- Requires health plans to be offered by AHPs; CHPAs may not directly provide insurance, directly contract with a health care provider, or bear risk

Medicaid

- Creates the MedAccess Program (Medicaid Buy-In) for Floridians with incomes up to 250 percent of the federal poverty level; premiums will be paid by the individual, the individual and the employer, or government; providers will be compensated at the Medicaid reimbursement rates; includes the benefits participants will receive under the program

- Creates a new physician fee schedule based on a resource-based relative value scale

- Expands the MediPass primary care case management program statewide by December, 1996

Small Business Health Insurance Reform

- Enhances the Employee Health Care Access Act of 1992 by extending reforms to include employers with 1 to 50 employees

- Requires all small employer carriers to offer their product on a "guarantee issue" basis to small employers, employees, and dependents without regard to health status, preexisting conditions, or claims history

- Requires modified community rating of small business products; adjustments are allowed for age, gender, family composition, tobacco usage, and geographic location

Single State Agency

- Implements 1992 reforms by transferring Medicaid and the policy making and negotiating functions of the State Employees' Health Insurance Program to the Agency for Health Care Administration, effective July 1, 1993

Practice Parameters

- Amends 1992 reforms, by directing the agency, in conjunction with the health professional boards and associations, to develop state practice parameters that will reduce unwarranted variation in the delivery of medical treatment, improve the quality of medical care, and promote the appropriate use of health care services

- Provides for the agency, in conjunction with the Board of Medicine, to establish a demonstration project to evaluate the effectiveness of practice parameters with regard to the costs of defensive medicine and professional liability insurance

Rural Health

- Creates rural health networks that provide a continuum of care, integrate public and private resources, coordinate health service planning among providers, and link rural and urban facilities

- Provides certificate of need preferences, a disproportionate share program for statutory rural hospitals, and a rural hospital financial assistance program if federal funding is not available to implement the disproportionate share program

Special Studies

- Requires the Agency for Health Care Administration (1) to actively supervise the CHPAs to ensure that actions that affect market competition are not for private interests, but accomplish legislative intent, and (2) in conjunction with other agencies, to conduct an anti-trust study, including developing methodologies for regulation and state oversight; allowing providers to form AHPs; preventing the formation of monopolies and oligopolies; preventing predatory pricing; and making recommendations for specific changes in federal and state anti-trust laws to facilitate the objectives of Florida's health reform law

- Directs the Agency for Health Care Administration to conduct a fraud and abuse study and develop strategies to solve fraud and abuse problems

Although the federal government should support state initiatives to provide full coverage of their residents and operate cost-effective health care programs, it has strong interests in ensuring that states will carry out the intent of the federal programs. Florida suggests that the following general principles guide decisions on state flexibility:

- the state's health care reforms must be comprehensive, ensuring access to care for all residents by a certain date;
- the state's reforms must be compatible with reforms enacted at the federal level;
- the state must agree to enter into an outcome-based performance contract in exchange for being granted waivers or exemptions from federal requirements;
- benefits must include preventive and primary care in the basic plan design; and
- a state must be able to demonstrate that it has either enacted legislation or has the support necessary to pass its health care reforms into state law.

The following sections outline the federal statutory and regulatory changes Florida needs to implement its comprehensive health care reforms.

Medicaid

State Comprehensive Health Care Reforms

Florida has identified several problems with federal Medicaid statutes and regulations that prevent the states from ensuring access to health care for all their residents, operating cost-effective programs, and implementing other comprehensive health care reforms. For example, state efforts to cover additional low-income, unemployed or part-time workers, implement wide-scale managed care programs, and demonstrate other cost containment measures have been limited by Medicaid categorical and income limits, the linkage of federally supported public and medical assistance eligibility, managed care limitations, and federal financial participation restrictions.

There are several federal Medicaid constraints to the full implementation of Florida's health reform laws, including improved coverages for people with low incomes. Some of the major constraints are:

- Categorical and income restrictions. Title XIX of the Social Security Act specifies the groups that states are required to cover in their Medicaid programs based on categorical eligibility requirements. Consequently, federal funding is not currently available for health care coverages for other low-income persons who are categorically ineligible for Medicaid. To some extent, the states can overcome this problem by increasing their AFDC income standards, but this requires them to provide economic benefits in order to offer medical assistance. Even then, assistance is limited to individuals who are categorically eligible. Like many other states, Florida could increase its AFDC income standards, thereby increasing federal expenditures for both economic and medical assistance. However, by decoupling economic and medical assistance income eligibility, Florida would be able to improve its health coverages without increasing federal expenditures for its economic assistance programs.
- Managed care. Another aspect of Florida's health reform laws is an increased reliance on managed care programs for persons enrolled in publicly sponsored health plans. Although the Social Security Act permits renewable two-year freedom-of-choice waiver programs, such as Florida's primary care case management program (MediPass), regulations have significantly limited the expansion of Medicaid managed care plans. To ensure quality of care, the Social Security Act requires Medicaid HMOs and other prepaid health plans (PHPs) to maintain a 25 percent commercial (non-Medicaid, non-Medicare) enrollment. The commercial enrollment requirement, however, is a poor proxy for quality. To require that one-fourth of Medicaid PHP enrollees be commercially insured inhibits Medicaid PHP development. It also forces many

Medicaid PHPs to accept high-risk commercial accounts simply to satisfy the Medicaid-commercial mix requirement, threatening the PHP's financial ability to deliver quality care. HCFA requires states to contract for an outside evaluation of the cost-effectiveness of their freedom-of-choice waiver programs every two-year renewal period. This time frame does not provide contractors adequate time to collect sufficient data to support a meaningful assessment. Moreover, it wastes state and federal funds to continue to evaluate programs that have already proven to be cost-effective.

Improved Program Management

There are additional refinements that could be made to allow states to improve the management of their Medicaid programs. These changes would provide the flexibility states need to ensure access to care, while constraining health care costs and protecting quality of care.

Florida proposes that Congress and HCFA generally limit their regulation to establishing broad parameters for state programs (e.g., eligibility, service coverage, federal financial participation), only requiring a state to demonstrate that it has sufficient providers, adequate reimbursement, proper quality of care, and other program features to ensure that the state offers accessible, adequate care to all Medicaid-eligible persons.

The goals of the states and the federal government to ensure access to high-quality, cost-efficient health care are the same. Over time, however, the federal government has promulgated laws and rules that constrain and even compete with the states' abilities to achieve these goals by micromanaging the Medicaid Program. What began in 1965 as a partnership between the federal government and the states to provide health care coverage for low-income Americans has evolved into a "top-down" approach to management of the Medicaid program, with the federal government issuing mandates and the states being forced to comply.

The following examples illustrate some of the areas in which the states need regulatory relief:

- States can obtain waivers to certain sections of the Social Security Act to operate cost-effective alternatives to the regular Medicaid program. President Clinton stated his commitment to speeding up the waiver process and HCFA recently granted Oregon a waiver, which had been rejected by the Bush Administration, to test its Medicaid reforms. The President is aware that because states invest a substantial share of their own revenues in the Medicaid program, they have strong financial incentives to make sure that they operate cost-effectively. For states that are trying to revolutionize their health systems, and incurring all the political and economic unrest associated with such a change, delays can be discouraging. Florida appreciates President Clinton's understanding of the states' dilemmas and wants to work with the Administration to improve the waiver process. Some additional reforms that should be considered include extending the time frame for collecting data to analyze waiver renewal requests, thereby permitting a more valid analysis and streamlining the renewal evaluation process.

- To contain Medicaid acute and long-term care expenditures, the Boren Amendment was enacted, requiring the states to reimburse facilities at rates that are adequate to cover the cost of an economically and efficiently operated facility. Congress intended to create reimbursement ceilings. However, the amendment has been interpreted by HCFA and the courts in a manner that establishes a reimbursement floor, increasing state Medicaid program expenditures.

- The Social Security Act and federal regulations sometimes require the states to implement program reforms that increase costs but do not improve care. For example, OBRA 90 requires the states to cover any drug manufactured by a pharmaceutical firm if the manufacturer has signed a rebate agreement with HCFA. States should be permitted to deny reimbursement for any manufacturer's drug if other drugs in the same class of drugs are as effective but less costly. In addition, states are required to pay the Medicare Part A and Part B premiums for certain Medicare beneficiaries. As a

result, the state may pay more for a beneficiary's premiums, coinsurance, and deductibles than it would have paid for total Medicaid coverage of the individual.

- States may lose valuable Medicaid matching funds for minor technical infractions which do not affect quality of care. Disallowances for infractions that do not affect Medicaid recipients' access to or quality of care cost the state millions of dollars, reducing available funds for meeting critical state needs.

Medicare

Medicare is a federally administered entitlement program that provides comprehensive health care benefits for elders and some disabled persons. However, current Medicare statutes only allow state-administered cost control demonstrations. Under these demonstration authorities, HCFA has supported a variety of Medicare and Medicaid prospective reimbursement and rate-setting programs administered by several states. However, more recently HCFA has narrowed its demonstration interests, virtually ignoring the Congressionally authorized waivers to further test state cost control systems.

Because of extraordinary increases in Medicare expenditures, state innovations in managed care and utilization control programs, and state comprehensive health care reform proposals, the federal government should authorize state demonstrations to learn how to better control Medicare beneficiaries' use of services, improve the quality of needed care, and contain per capita costs. States are more knowledgeable of their populations and health care systems than the federal government is, but their unique ability to plan programs for Medicare beneficiaries that provide greater levels of service at less cost is hampered by rigid, uniform regulation.

Employee Retirement Income Security Act

The Employee Retirement Income Security Act of 1974 (ERISA) preempts state regulation of employee benefit plans, including employer self-funded health insurance plans. Advocates for continued ERISA preemption want to prevent four things: (1) state regulation of health and pension plans negotiated by management and labor; (2) state interference in collective bargaining; (3) state taxation of premiums; and (4) dilution of the pressure on Congress and the President to enact a national health plan. However, this preemption no longer serves the nation's interest. It will delay the further development and implementation of the states' comprehensive health care reforms that include universal coverage, "play or pay" employer mandates, and mandated benefit floors for all insurers.

Chairman STARK. Ms. O'Brien.

STATEMENT OF MARY JO O'BRIEN, DEPUTY COMMISSIONER, MINNESOTA DEPARTMENT OF HEALTH

Ms. O'BRIEN. Thank you, Mr. Chairman, for allowing me to be here. And I send greetings from Governor Arne Carlson for allowing us to present before your committee.

Minnesota has made a serious and comprehensive commitment both to providing access and to cost containment. We passed major reform legislation in 1992, and this year we once again passed another phase of our reform legislation where we have gotten more serious about access and cost control.

Our law requires the Minnesota Health Care Commission, made up of representatives of consumers, unions, employers, providers and insurers, to develop by December 15, 1993, a plan that will lead to universal coverage by January 1, 1997.

However, even before the development of the universal coverage plan, Minnesota has taken several major steps toward preserving or expanding access. Our 1992 reform law created the MinnesotaCare program. That program is already providing State-subsidized health insurance coverage to more than 53,000 previously uninsured Minesotans. That program just began this last October 1, 1992.

Our plan is that we will be serving through the MinnesotaCare subsidized coverage to 170,000 Minesotans by January 1, 1997. That program is being funded by a 2 percent provider tax. So we have put the funding on the table, Mr. Chairman, and have committed that that program is fully funded.

Our 1992 reform law also featured substantial new insurance regulation in the small employer and individual market. These reforms go into effect July 1, 1993, address insurers' reluctance to cover higher risk groups and individuals. The 1992 law also promotes access for small employer groups by creating a more basic and affordable health insurance product and by creating a program to enable employers to pool their purchasing power in order to get better premium rates.

Another type of access measure in the 1992 law focuses on not only access to health insurance but access to health care itself. And the 1992 law took two steps to remedy access problems in specifically the medical assistance program. Provider reimbursement rates, particularly for primary and preventive care, were increased by up to 25 percent. What we did not want to do is establish the subsidized health insurance program and not have access for our medical assistance population to primary care and preventive care.

Additionally, providers were required to serve Medicaid or medical assistance patients as a condition of doing business with more financially desirable State groups such as State employees and workers compensation patients.

The 1992 law also promotes access to care for our rural population and provides for the establishment of community health centers which are jointly funded centers both by local units of government and the State.

Minnesota's cost control plan was enacted as part of the health care reform law signed several weeks ago. The 1993 law sets out

two basic cost containment strategies, fundamentally reconfiguring the delivery system and placing regulatory controls on the amount of cost that can increase, essentially, expenditure limits.

The 1993 law replaces the existing delivery system with a new two-part delivery system. Health care will be delivered principally through integrated service networks, integrated delivery systems, and care that is delivered outside these integrated delivery systems will be governed by a regulated all-payer system.

It is Minnesota's clear intent we are going to move quickly to a provision of services by capitated integrated delivery systems. These integrated delivery systems will be provider networks that will be responsible for providing the full range of care to a defined population for a capitated premium.

Integrated delivery systems help contain costs in several ways. Most fundamentally capitation will create incentives not to provide unnecessary care but to provide quality cost-effective care.

And in Minnesota we have done a lot of work on managed care systems, and we continue to want to move forward. Our goal of our health care commission is to have between 80 and 90 percent of our population in these capitated systems within the next 4 years.

Cost containment will also result from the integrated service structure as networks bring about collaboration and achieve economies of scale by eliminating enormous amounts of unnecessary duplication. In the 1993 law we had provided a State exemption process from antitrust, and our hope is that meets the Federal test. We spent a great deal of time on that, working with both the Federal Justice Department and our attorney general's office.

The second basic strategy of our 1993 law is the imposition of an overall systemwide spending limit. These limitations will serve as a global budget to assure spending cannot exceed a certain level or point, and our short-term transitional limits on providers and insurers will be in effect in 1994 and 1995. Subsequently, limits will apply to the integrated service networks and to the all-payer system as a basic part of the new delivery system.

Chairman STARK. Do you have a penalty if someone goes over those limits or are those voluntary targets?

Ms. O'BRIEN. In 1994 and 1995, as we develop the data systems, which we are developing now—Mr. Chairman, I can't reiterate the problem of having sufficient expenditure information available to you so that you can make sure that the expenditure limits that you are designing are appropriate, especially where you will be providing them to individual insurers and providers.

Chairman STARK. When do they become enforceable?

Ms. O'BRIEN. The 1994–95 will be voluntary. I would say they will be voluntary under agreement and duress. We are going to go in and actually——

Chairman STARK. So they are not enforceable?

Ms. O'BRIEN. We will be auditing them, and we will be publicizing those providers and insurers that go over those amounts.

Mr. THOMAS. Mr. Chairman, this is Minnesota. Guilt is inborn.

Ms. O'BRIEN. Some people would say——

Mr. THOMAS. It will work in Minnesota.

Ms. O'BRIEN. Some people keep on telling me, Mr. Chairman, it is in our water, and we have agreed to export that water if it would help.

Mr. THOMAS. You used to have it in the beer, but you don't as much any more.

Ms. O'BRIEN. Excuse me, I didn't hear that.

Mr. THOMAS. I am sorry. Go ahead.

Ms. O'BRIEN. I am not a beer drinker, Mr. Thomas.

After 1994 and 1995, they will be enforceable. We will have the statutory—we actually have the statutory authority to go back in and assess the providers if they exceed the limits, and we are to come back to our legislature this coming January 1, 1994, with specific enforcement regulations.

Chairman STARK. You have to get those passed.

Ms. O'BRIEN. Yes, we do.

But, Mr. Chairman, I need to tell you that these expenditure limits were at the behest of both the business groups and labor groups in our State. They have broad bipartisan support. It is not my expectation we will have trouble getting expenditure limits passed.

And, in fact, we have in our statute specific levels for expenditure limits that are outlined for the next 5 years, and it is the clear intent of our State and our State groups to abide by these limits.

Chairman STARK. Great.

Mr. THOMAS. And they will.

[The prepared statement follows:]

PREPARED STATEMENT OF MARY JO O'BRIEN

To the Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
June 8, 1993

My name is Mary Jo O'Brien. I am the Deputy Commissioner of the Minnesota Department of Health. I was the lead person for Governor Carlson's administration in the development of Minnesota's 1992 bipartisan health care reform initiative. With the passage of that law, I assumed overall responsibility for its development and implementation. I worked closely with the Minnesota Health Care Commission in the development of Minnesota's cost containment plan.

Minnesota has made a serious and comprehensive commitment to providing access to health care and to containing the increase in health care costs. The reform process began in April 1992 with the enactment of the HealthRight (now "MinnesotaCare") Act, and continued last month when Governor Carlson signed another major health care reform law that builds on the framework enacted last year.

I will respond in turn to the four questions posed by the subcommittee (I will refer to the HealthRight Act as the "1992 law", and to the legislation enacted last month as the "1993 law").

I. To what extent does Minnesota guarantee health insurance coverage to all residents by a specified date?

II. What specific policies and enforcement mechanisms are used to expand access and coverage?

The 1993 law commits Minnesota to guaranteeing universal coverage by January 1, 1997: "The health care commission shall develop and submit to the legislature and the Governor by December 15, 1993, a comprehensive plan that will lead to universal health coverage for all Minnesotans by January 1, 1997."

Even before the development of the universal coverage plan, Minnesota has already taken several significant steps toward preserving or expanding its citizens' access to health insurance and to health care.

a. <u>State-subsidized insurance for the working poor</u>.

The 1992 law created the MinnesotaCare program. That program is already providing state-subsidized health coverage to thousands of previously uninsured Minnesotans. The program is available to the uninsured with family incomes below 275 percent of the federal poverty level who do not qualify for Medicaid. Premiums are paid in part by the enrollees and in part by the state (the amount of the state's subsidy is determined on a sliding scale based on income and family size).

The MinnesotaCare program is an expansion of an existing program called the Children's Health Plan and, like the Children's Health Plan, it emphasizes preventive care. However, it goes far beyond the Children's Health Plan, by also covering adults (adults with children are eligible already; childless adults will be eligible beginning in July 1994) and by providing inpatient benefits (unlimited for children, up to $10,000 for adults).

Over 53,000 previously uninsured Minnesotans already receive insurance coverage through the MinnesotaCare program. The state projects that, by 1997, more than 170,000 people (almost half of Minnesota's uninsured population) will be enrolled.

b. <u>Small-group and individual market insurance reform</u>.

The 1992 law featured substantial insurance reform in the small employer (fewer than 30 employees) and individual markets. These reforms, which go into effect on July 1, 1993, address the access problems that arise from insurors' reluctance to cover those who most need insurance. The 1992 law's insurance reform includes the following: carriers may not refuse to cover

or to renew a small employer group ("guaranteed issue" and "guaranteed renewal"), and may not refuse to renew an individual policy; carriers may not carve out high risk individuals from a covered group; carriers may not base premium rates on gender; carriers must offer premium rates to small employers and individuals that are no more than 25 percent above or 25 per cent below their index rate, and divergences from the index rate may be based only on experience and health status (an additional divergence from the index rate of up to 50 percent may be based on age); carriers may not limit coverage based on pre-existing conditions for longer than twelve months; and an insured who has already been subject to a pre-existing condition limitation may not be subjected to a new limitation for the same condition upon changing carriers.

In addition to these regulatory reforms to the small group and individual markets, the 1992 law also promotes access to health coverage by creating a new, more affordable health insurance product in the small employer market. The 1992 law requires that carriers offer the "small employer plan" to any small employer who wishes to purchase it. The plan provides a more basic benefit package than is otherwise mandated under the Minnesota insurance law and will therefore be less expensive. The small employer plan provides inpatient and outpatient hospital services, physician and nurse practitioner services, X-rays and lab tests, ambulance services, durable medical equipment, maternity and prenatal care, and some chemical dependency, mental health, and prescription drug coverage. However, it does not provide other mandated coverages that cause the cost of health insurance to exceed the means of some small employers.

The insurance reforms in the 1992 law will discourage insurors from denying coverage to high-risk groups and individuals, and will prohibit such denials in the small employer market. But even before that law was enacted, Minnesota had a well-established high-risk pool that guaranteed coverage to those people who were turned down by the insurance carriers. The Minnesota Comprehensive Health Association (MCHA) was founded in 1976 as the nation's first high-risk pool and now covers 35,000 Minnesotans. MCHA is funded partly through enrollee premiums and partly through assessments on all licensed insurors (including HMOs and non-profit health plans). MCHA remains an important part of Minnesota's strategy for promoting access to coverage, by insuring high-risk individuals who are self-employed, retired, or employed by firms that do not provide insurance. However, the 1992 insurance reforms should significantly reduce Minnesota's reliance on MCHA as the insuror of last resort.

c. <u>Pooled purchasing</u>.

The 1992 law also seeks to improve access for employees through the Private Employers Insurance Program. This program will enable employers to pool their purchasing power in order to get better premium rates. The program, based on a successful existing program for small public employers (counties, municipalities, and school districts), is administered by the state, but is not otherwise subsidized by the state.

d. <u>Tax deductibility for the self-employed</u>.

Another access measure in the 1992 law increased from 25 percent to 100 percent the portion of health insurance premiums that may be deducted by the self-employed from their state income tax. This measure will assist farmers and other self-employed individuals, who often face high premiums due to their lack of purchasing power, to afford health insurance.

e. <u>Access to Medicaid providers</u>.

Another type of access measure in the 1992 law focuses not on access to health insurance, but on access to health care itself. Merely having insurance coverage is not enough, if that coverage does not assure access to health care providers. Enrollees in our Medicaid program had experienced significant access problems due to the reluctance of providers to serve them. The 1992 law took two steps to remedy this access problem. Provider reimbursement rates, particularly for primary and preventive care, were

increased by up to 25 percent, in order to narrow the gap between the financial rewards for treating privately insured patients and Medicaid patients. Additionally, providers were required to serve Medicaid and MinnesotaCare patients as a condition of doing business with the State Employees Health Plan and the worker's compensation program (generally viewed by providers as more financially desirable groups).

f. Access to rural health care.

The 1992 law promotes access to care not only for our Medicaid population, but also for our rural population. The law creates an Office of Rural Health within the Department of Health, to act as an advocate, creator, and coordinator of rural health programs. The law also establishes several hospital grant programs, including one for rural hospitals in isolated parts of the state.

The 1992 law provides for the establishment of community health centers in underserved rural areas. The state will provide technical and financial assistance to the community health centers, which will be locally operated and will encourage the use of midlevel practitioners. State funds provided to community health centers must be matched by local funding.

Finally, the 1992 law includes education loan forgiveness programs for physicians and midlevel practitioners who commit to practice in rural Minnesota. Those programs were expanded upon in the 1993 law.

III. Is the plan designed to control the growth in public and private health spending?

IV. What specific provisions were adopted to limit the growth in spending?

The central focus of the 1993 law is controlling the growth in health spending. The law sets out two basic strategies for accomplishing this. The first is to fundamentally reconfigure the delivery system and the second is to place regulatory controls on the amount that costs can increase.

Both strategies are being implemented with a foundation of citizen support and participation. Through six regional boards, a statewide commission and several advisory committees, development and promotion of both strategies has begun. I believe this early and intense involvement of key community leaders has allowed us to move forward with our reforms and toward our vision of creating a seamless delivery system with universal access.

The specifics of our two basic strategies are as follows:

a. Delivery system reform.

The 1993 law replaces the current delivery system, still largely based on traditional fee-for-service medicine, with a new, two-part system. Health care will be delivered principally through "Integrated Service Networks" (ISNs); care delivered outside of ISNs will be governed by a regulated all-payer system.

ISNs will be provider networks that will be responsible for providing the full range of acute and preventive care to a defined enrollee population for a pre-determined, capitated premium. They may be formed by health maintenance organizations, insurors, hospitals, providers, local government, purchasers, or by some combination of those entities.

ISNs will contain costs in several ways. Most fundamentally, they will create incentives not to provide unnecessary or marginal care. Under the existing fee-for-service system, a provider who performs more tests and procedures makes more money. Under the ISN system, based on capitation, doing more will mean earning less. The ISN and its member providers will have a strong incentive to hold down the cost of care.

Cost containment will result not only from the ISN being capitated, but also from it being a network. The existing system imposes an array of unnecessary costs as a result of its fragmentation. Administrative functions are duplicated in each provider's office; expensive diagnostic machines are purchased both by a hospital and by the clinic across the street. Delivery of care through provider networks will bring about provider collaboration to achieve economics of scale that eliminates an enormous amount of unnecessary duplication.

The 1992 and 1993 laws further promote beneficial collaboration among providers by establishing a process by which an arrangement that would improve the cost, access, or quality of health care would be exempt from federal and state antitrust liability (as permitted under the "state action doctrine" of federal antitrust law). Under this process, providers wishing to collaborate in a manner that may violate antitrust law can apply to the Commissioner of Health for an exemption. The Commissioner will provide an opportunity for any member of the community to comment and will seek advice from the state health care commission and pertinent regional coordinating boards, and may conduct a hearing. If the Commissioner then finds that the arrangement would improve cost, access, or quality, the Commissioner may grant an exemption, and will monitor the arrangement as it goes forward, in order to assure that it actually benefits consumers as expected rather than merely enriching the participants. If abuses occur, the Commissioner may revoke the approval.

Minnesota's plan relies on competition as well as collaboration. ISNs will contain costs not only through collaboration within an ISN network, but through competition between ISN networks. ISNs will compete in a manner that better enables health care purchasers to make rational decisions. Competition in health care currently does little or nothing to hold down health care costs, largely because the health care "product" is so ill-defined in the current market. Purchasers of care through ISNs will be able to compare two essential measures of competing ISNs: quality (a major thrust of our reform effort is to collect and disseminate outcome and consumer satisfaction data to meaningfully measure ISN quality) and price. ISN benefit packages will be standardized to enable comparisons to be made between different ISNs in a more intelligible way than can currently be done between providers or health insurance plans. Health care purchasers will thereby be able to exert a significant pressure on ISNs to hold down their premium rates and improve quality, because ISNs that fail to do so will lose business to competing ISNs.

A fundamental difference between Minnesota's ISN model and current health maintenance organizations is that the ISN will "integrate" community and regional public health goals into its delivery of care. ISNs will be judged in part on their achievement of these goals, which will bring about a strong community focus and involvement for this new delivery system.

ISNs will begin providing care on July 1, 1994. Also on July 1, 1994, a two-year phase-in will begin of the regulated all-payer system, the other component of our new delivery system. That regulatory system will govern all health care that is not provided through ISNs. Providers, insurors, and purchasers who choose not to work through an ISN will be governed by the all-payer system. The state will set provider fees in the all-payer system, and will establish utilization controls and restrictions on provider conflict of interest and self-referral. The all-payer system will assure that, even outside of ISNs, there are no incentives to drive up fees, utilization, and insurance premiums.

b. Regulatory control of spending growth.

Our 1993 law pairs delivery system reform with over-all, system-wide spending limitations. These limitations will serve as a global budget, to assure that spending cannot exceed a certain point. Our expenditure limits are designed to carry out the requirement in our 1992 law that our new system must reduce the growth rate of health care spending by 10 percent per year for five years.

The 1993 law contains two types of spending limits. Short-term, transitional limits will be in effect in 1994 and 1995 to assure that spending is kept in check during the period in which we are moving into the ISN/all-payer system. Additionally, limits will apply to the ISNs and to the all-payer system, as a basic part of that new system.

The transitional 1994 and 1995 limits apply to both providers and insurors. In 1994, providers may not increase their annual per-patient revenues more than 6.5 percent plus the increase in the CPI; in 1995, that limit drops to 5.3 percent plus the increase in the CPI.

Insurors' (including HMOs and such non-profit health plans as Blue Cross/Blue Shield) expenditures are subject to the same maximum rates of increase as are providers' revenues. Insurance premiums will be regulated and reserve levels monitored to assure that insurers pass on to consumers the savings resulting from provider fee limitations and from the limits on insuror expenditures. Providers or insurors that exceed the revenue or expenditure limits will be required to pay an assessment to the state, equal to the excessive amount.

The limits applicable to ISNs and to the all-payer system will work in a similar way. Each ISN will be required to keep its revenues and spending within the statutory growth rates (which decrease every year until 1998, when the growth rate will be 2.6 percent plus the increase in the CPI), and will be sanctioned for any excess spending. The same limits will be imposed on the all-payer system as well, and will be enforced through adjustments of the fee schedule.

Both the transitional limits and those applied to the new delivery system may be adjusted by the Commissioner of Health for changes in enrollee population that affect the risk associated with the population and the intensity of care that the population requires. Such adjustments will avoid creating incentives for providers and insurors to avoid high risk people, and reward those providers and insurors that do take on such patients and enrollees.

Minnesota is very confident that its delivery system reforms, together with regulatory limits on spending growth, will contain health care costs while preserving the high quality of care in the system.

BACKGROUND: Development and Implementation of Minnesota's Plan

I will give the subcommittee a sense of how Minnesota's plan evolved, and of the activity inspired by our legislation that is now going on throughout the state. This background will help explain why we in Minnesota are so optimistic about what we are doing, and why we think a significant amount of state flexibility is an important element of a successful health care reform initiative.

The 1992 law

The bill that passed in 1992 was drafted by a bipartisan legislative team working in conjunction with the Governor's Office. It was supported by the legislative leadership of both parties and by the Governor. Even with that support, the bill was extremely controversial, and very nearly defeated. Hundreds of physicians came to the Capitol to lobby against it, and it was also bitterly opposed by rural hospitals and other stakeholder groups. The House of Representatives passed the bill by a narrow 70 to 64 margin.

The Minnesota Health Care Commission

The 1992 law, in addition to the many access provisions already discussed, created the Minnesota Health Care Commission and charged it with developing a cost containment plan. The 25 member Commission is broadly representative of the many stakeholders in our health care system. It includes representatives of consumers, large and small employers, labor unions, insurors (including HMOs, Blue Cross/Blue Shield, and indemnity insurance

companies), and providers (including representatives of the state hospital association, medical association, and nurses association, a rural physician, and a chiropractor).

The 1993 Law

The cost containment plan enacted in the 1993 law was essentially the creation of the Health Care Commission. The Commission's cost containment plan, unanimously supported by its 25 members, was released in January 1993, and forms the heart of the 1993 law. All major stakeholder groups supported the bill and lobbied for it, and the bill passed the legislature by a wide margin.

Response to the Reform Initiatives

Providers, insurors, and communities all over the state, in rural areas as well as in the Twin Cities, are already moving forward to implement the delivery system reforms envisioned in the law. A large collection of providers has already announced an equal partnership with Blue Cross/Blue Shield to form an ISN covering a rural 14 county area around the city of Willmar. Interest has been expressed by Mayo Clinic physicians in developing an ISN to serve the Rochester area. ISN planning and developmental activities are under way in at least a dozen cities and towns outside of the Twin Cities metropolitan area, and the major Twin Cities providers are actively positioning themselves to play a role in the new ISN system. Numerous communities have requested advice or technical assistance in forming ISNs, and several have volunteered to serve as Department of Health "models" for ISN development. All this activity is going on in an atmosphere of excitement over a real opportunity to improve the system, rather than reluctant acceptance of the inevitable.

The support for reform expressed by stakeholders and legislators, and the dramatic private sector response to the reform initiatives, would not have been possible were our reform initiatives not state-based. The state commission served as a vehicle for educating different groups, for giving them an opportunity for voicing their concerns and priorities, and for assuring that the plan that emerged was one that would be widely acceptable.

I believe that the plan's "grass roots" origins have played a key role in its acceptance and in its promise for the future, and that a plan imposed from Washington would not have produced the same encouraging progress.

I look forward to the subcommittee periodically reviewing Minnesota's health care reform efforts.

Chairman STARK. Miss Rader.

STATEMENT OF ANYA RADER, DEPUTY CHIEF OF STAFF FOR GOVERNOR HOWARD DEAN, M.D., STATE OF VERMONT

Ms. RADER. Thank you. I am Anya Rader, deputy chief of staff for Governor Howard Dean of Vermont, and I thank you on behalf of Governor Dean and myself for the opportunity to testify today.

In Vermont we are aiming to provide access to a comprehensive set of health care benefits for all residents in the State by 1995.

The Vermont legislature passed health reform legislation in 1992 that created the foundation for a dramatic restructuring of our State's health care system. The legislation followed on the heels of insurance market reforms enacted in 1991 which required community rating and guaranteed acceptance in the Vermont market.

Vermont's reform bill reorganized and strengthened health care regulation in our State by creating a health care authority with considerable powers. The authority is developing a global budgeting process through which we will annually set the rate of growth in Vermont's health care expenditures.

Vermont's reform legislation also created a purchasing pool similar to the health alliance that is being discussed at the Federal level, and Governor Dean has advocated requiring all Vermonters join the pool, including Medicaid and Medicare eligibles with appropriate Federal permissions.

The bill also expanded coverage through Vermont's Medicaid program to include children up through age 17 living at or below 225 percent of the Federal poverty line.

Lastly, and most importantly, Vermont's reform legislation initiated the creation of integrated systems of health care delivery. It is expected that all Vermonters will receive their health care through an integrated system in the future after further legislative action.

These networks of providers will be certified by our health care authority. They will be required to make available a standard package of benefits to anyone in the State, and they will be the locus of enforcement of the global budget. The integrated systems will receive a capitated payment for each enrollee, and the rate of growth in that payment will be controlled by the authority.

The health care authority is developing two comprehensive models for raising the necessary revenues to pay for universal coverage, a single-payer version, relying on a payroll tax, and an employment-based model which relies on a number of splinter taxes. The Vermont legislature is expected to adopt one of these two financing models, including the revenue raising measures during their 1994 session, and that same legislation will include a benefits package and other further overall system reforms.

We are proud of our accomplishments in Vermont. Governor Dean is determined to move ahead with the next phase of reform, but we cannot deny our chances of success will be greatly enhanced by action at the Federal level. At a minimum, we need to see the removal of Federal barriers for States that want to pursue comprehensive health care reform but are inhibited by Federal laws and regulations.

The participation of Medicaid, Medicare and ERISA plans is essential to the success of Vermont's reform efforts. Coordination of policies regarding administration, benefits, provider payment and financing will enhance our ability to meet our reform goals. An expedited waiver process for inclusion of Medicaid and Medicare and comprehensive reform designs is needed along with statutory changes to ERISA.

States also need a reform framework at the national level that creates common standards of accountability and general parameters for our efforts. Vermont cannot go it alone forever. If we are financing coverage for all our citizens and our neighbors are not, we will be at a competitive disadvantage, and our cost control efforts will be undermined by the lack of controls in neighboring States.

So I would say while movement at the State level is a positive thing and should be encouraged, it is not a replacement for national reform. Cost control, financing and access expansion requirements, insurance reform, tort reform, antitrust reform and benefits and quality standards, these basic elements and the standards through which they are assured should be established at the Federal level.

States should have to meet specific, realistic cost containment targets or caps. They should have to meet access expansion requirements. They should be required to establish the basic structures necessary to carry out reform, and they should be held to quality standards for the care that they guarantee to their citizens.

We know there is some nervousness about allowing different State approaches to reform, but with this type of framework in place there would be enough commonality to assure accountability at the Federal level yet it allows us to do what is needed at the local level to assure long-term success of reforms. It is the outcomes that are important, and if you design a system that holds us accountable for the outcomes, for how we treat our poor and underserved, how well we control cost increases, you need not be as concerned about the methods we use to get there.

Some Federal action this year, whether it be a comprehensive reform bill or greater flexibility for States such as ours, is essential. It will allow States such as those that are before you today to continue moving head, and we believe that progress will benefit the entire country.

Thank you and thanks again for letting me be here.

Chairman STARK. Thank you very much.

[The prepared statement follows:]

Testimony of Anya Rader
Deputy Chief of Staff
Vermont Governor's Office

before the Subcommittee on Health of the
House Committee on Ways and Means
June 8, 1993

Mr. Chairman and members of the subcommittee, thank you for the opportunity to testify today. My name is Anya Rader and I am Deputy Chief of Staff for Governor Howard Dean of Vermont. I am going to briefly describe Vermont's health reform plans and our views on the state role in national health reform.

In Vermont we are aiming to provide access to a comprehensive set of health care benefits for all residents of the state by 1995. The estimated cost of full coverage for the state's uninsured population is about $66 million. Vermont is blessed with a relatively efficient, low cost health care system. We have only fifteen acute care hospitals in the state, all of them non-profit, and we have a history of tight regulation of our health care providers, including hospital budget controls and a strict certificate of need law. Our efficient health care system has come about not through market competition among health care providers, but from careful allocation of resources and the cooperation of a high quality provider community.

The Vermont legislature passed health reform legislation in 1992 that created the foundation for a dramatic restructuring of our state's health care system, to allow even greater efficiency and coverage of all Vermonters. The legislation followed on the heels of insurance market reforms enacted in 1991 which required community rating and guaranteed acceptance in the Vermont market.

The 1992 bill addressed three basic levels of reform -- regulatory reform, purchaser reform and delivery system reform. In addition, the legislation expanded coverage through Vermont's Medicaid program to include children up to age eighteen living at or below 225% of poverty.

Vermont's reform bill reorganized and strengthened health care regulation in our state by creating a Health Care Authority with the power to control total system costs and oversee resource allocation and health planning. The Authority is developing a global budgeting process through which we will annually fix the rate of growth in Vermont's health care expenditures. They are also developing a health care database that will give us information on health care costs, utilization and quality.

Vermont's reform legislation also included changes to our purchasing system. We have created a purchasing pool, similar to the health alliances discussed at the federal level, which can serve in the future as a vehicle for consolidating health care purchasing power for effective negotiations with providers. The pool can also provide information to consumers about available health plans. Governor Dean has advocated requiring that all Vermonters join the pool, including Medicaid and Medicare eligibles.

Lastly, and most importantly, Vermont's reform legislation initiated the creation of integrated systems of health care delivery. It is expected that all Vermonters will receive their health care through an integrated system in the future. These networks of providers will be certified by our Health Care Authority. They will be required to make available a standard package of benefits to anyone in the state, and they will be the locus of enforcement of the global budget. The integrated systems will receive a capitated payment for each enrollee, and the rate of growth in that payment will be controlled by the Authority, subject to negotiations with the integrated systems.

Unanswered by Vermont's 1992 legislation is the question of how to finance universal coverage for the state's residents. The Health Care Authority is developing two comprehensive models for raising the necessary revenues to pay for coverage and funneling those funds to health plans. The first model, a single payer, would raise the

revenues by means of a payroll tax. Payroll tax revenues would flow through a single source to health plans, and coverage would not be linked to employment. Our most recent estimate indicates that an 11% payroll tax would be necessary to cover the total costs of Vermont's acute care health system.

Under the second model being developed by the Authority, employed people would receive coverage through their employers and a variety of taxes would be raised to subsidize that coverage and pay for the unemployed. Funds would not necessarily flow through a single purchasing entity, though they could.

The Vermont legislature is expected to adopt one of these two financing models during their 1994 session.

We are proud of our accomplishments in Vermont. Governor Dean will pursue the next phase of reform with vigor. We cannot deny, however, that our chances of success will be greatly enhanced by action at the federal level.

What we need from the federal government? At a minimum, we need to see the removal of federal barriers for states such as those represented here today that want to pursue comprehensive health care reforms but are inhibited by federal laws and regulations. The participation of Medicaid, Medicare and ERISA plans is essential to the success of Vermont's reform efforts. Coordination of policies regarding administration, benefits, provider payment and financing will enhance greatly our ability to meet our reform goals. An expedited waiver process for inclusion of Medicaid and Medicare in comprehensive reform designs is needed, along with statutory changes to ERISA.

Ultimately, states need a reform framework at the national level that creates common standards of accountability and general parameters for state efforts and we need that framework to be in place very quickly. Vermont can't go it alone forever. If we are financing coverage for all our citizens and our neighbors are not, we will be at a competitive disadvantage. Moreover, our cost control efforts will be undermined by the lack of controls in neighboring states.

Cost control, access expansion, insurance reform, tort reform, benefits and quality standards -- these basic elements, and the standards through which they are assured, should be established at the federal level. States should have to meet specific, realistic cost containment targets. They should have to meet access expansion requirements. They should be required to establish the basic structures necessary to carry out reform. And they should be held to quality standards for the care that they guarantee to their citizens. I also assume that a federal definition of financing mechanisms and requirements, whether it be through employer premium contributions, a payroll tax or other means, will be necessary.

One of the most important things Congress could do this year is to make sure that the states represented here, and others similarly situated, move ahead quickly. Innovative things are happening out there, progress toward universal access and effective cost containment is being made, and that should be encouraged. Our best bet for testing the appropriateness of various reform models for this country is to pilot some of those models in the states. This does not mean that we will have fifty different systems for health care financing and delivery. The type of framework I have described would result in enough commonality to assure accountability at the federal level. And it would allow for Vermont and Florida and Minnesota and similar states to continue moving ahead. To stop us dead in our tracks at this point would be a real shame, and it would hurt the cause that I believe we are all working for.

Thank you, again, for asking me to be here today.

Chairman STARK. Mr. Colmers, I think we have looked at your program as if it were only the hospital system, and you have an incipient physician program going. You might want to add that to the overview of what happens in Maryland. Proceed.

STATEMENT OF JOHN M. COLMERS, EXECUTIVE DIRECTOR, MARYLAND HEALTH SERVICES COST REVIEW COMMISSION

Mr. COLMERS. Thank you very much. I am in the unenviable position of standing between you and lunch, so I will be as brief but comprehensive as possible.

Chairman STARK. Don't rush.

Mr. COLMERS. Maryland has a long tradition of taking steps to assure its citizens both affordable and accessible health care services. For over 20 years the Maryland Hospital Rate Setting Commission has set a national example in its ability to control rapidly rising hospital expenses.

Since 1977, we have operated the country's most successful and currently only all-payer hospital payment system. The system is made possible by a Medicare waiver which is, in turn, made possible by actions of Congress including this committee and I thank Mr. Cardin and members of the committee for making that possible.

During the time period of the waiver, hospital costs in Maryland have fallen from 25 percent above the national average to 14 percent below the national average, while at the same time eliminating the rampant cost shifting that is prevalent elsewhere around the country. For example, the national average markup—that is the difference between a hospital's expenses and its gross charges—is 53 percent. In Maryland, it is only 14 percent, the lowest in the United States.

Thus, while unauthorized discounts are not permitted in Maryland, all payers purchasing hospital services are benefiting from a more equitable playing field.

It is important to recognize the critical role played by the Federal Government in our success. Maryland's program began as an experiment whereby the Federal Government provided Maryland the opportunity to design the system that would produce results in the hospital cost containment area proving worthy of continuation. Over the years, the Maryland system has saved Medicare and the other payers hundreds of millions of dollars while at the same time providing unparalleled financial access to needed hospital services through the uncompensated care provision.

I believe the enduring lesson to be learned from the Maryland success story is, first, given the flexibility by the Federal Government to be innovative and, second, providing the States enforceable targets, that is our waiver test, States have the ability to rise to the occasion.

As you mentioned, Mr. Chairman, in this past legislative session, the General Assembly of Maryland, building upon the tradition of the hospital rate setting system, embarked upon a new series of steps to reform the health care system in the nonhospital area and to undertake significant health insurance reform. House Bill 1359, entitled Health Care and Insurance Reform, establishes a new 7-member independent commission modeled after the Hospital Rate

Setting Commission to undertake several important tasks in the area of small market insurance reform and nonhospital cost control.

The most immediate responsibility of the new commission will be to establish a standard comprehensive benefit package which will be applied to all insurers including HMOs that offer products to employers from between 2 and 50 employees beginning July 1, 1994. This package must be balanced statutorily between an affordability limit and a breadth of coverage.

The legislation rewrites the ground rules for insurers offering products in this segment of the market. Products must be community rated with variation permitted only for differences in geography and age distribution. Limits are placed on preexisting condition restrictions, and eventually they are eliminated. Finally, there are provisions for guaranteed issue, guaranteed renewal and open enrollment.

Although the legislation requires neither that employers offer insurance nor that employees purchase insurance, the reform is designed to make insurance more affordable. House Bill 1359 also contemplates extending insurance reform to the entire insurance market, including individuals should a minimum threshold be achieved, a threshold that recognizes the need for a large enough population base over which to spread the financial burdens associated with providing insurance coverage to every Marylander.

Thus, House Bill 1359 envisions broader insurance coverage not through mandates but through inducements so that the business of insurance returns to what it once was—the assumption of risk spread broadly over a community.

The legislation also authorizes the new commission to establish a data base on nonhospital health care services as comprehensive and as accurate as the data base maintained by the Hospital Rate Setting Commission.

Whether one believes in a regulatory or a market-driven solution to rising health care expenses, there is an absolute need for timely and accurate information that is in the public domain. The new commission will analyze this data annually and publish the total reimbursement for all health care services, the rate of change, variations in fees and so forth.

The legislation also grants the commission the authority to establish a payment system for health care practitioners which will provide the framework for the determination of the ultimate price for health care services. The payment system will allow for a fair comparison of the cost and charges among practitioners. The commission may also establish health care annual adjustment goals by service or by a particular CPT code. And if compliance with those goals is not achieved on a voluntary basis, the commission may modify the payment system to ensure compliance.

The legislation also envisions the reduction of administrative expenses that can be achieved through the use of electronics claims clearinghouses, and the commission would have the authority to license such clearinghouses and regulate them in the State.

Finally, the legislation establishes a practice parameter advisory committee that may establish practice parameters for the State by specialty. As well-intentioned as House Bill 1359 is, there is, of

course, no guarantee the legislation will ultimately achieve all its purposes. Nevertheless, I believe it is fair to state that the bill represents one important piece of legislation which, taken in conjunction with the other legislative measures in place in Maryland, will enable the State to again achieve innovative and meaningful health care reform for the benefit of our citizens and our health care community.

Thank you very much.

Chairman STARK. Thank you.

[The prepared statement follows:]

TESTIMONY OF JOHN M. COLMERS[1]
MARYLAND HEALTH SERVICES COST REVIEW COMMISSION

I. INTRODUCTION

Maryland traditionally has demonstrated an ability to address creatively and effectively issues of health care affecting its citizens. In 1971, hospital costs in Maryland were spiraling far beyond the general rate of inflation in the economy. In response to this problem, the Maryland General Assembly took the initiative and created the Health Services Cost Review Commission ("HSCRC", or "Commission"), the first hospital rate setting system in the country, and now, in 1993, the longest running hospital rate regulation hospital program in history. The HSCRC began its rate setting functions in 1974, and over the last nineteen years, Maryland hospitals have consistently held their cost increases below national averages. Yet, despite our state's success in containing hospital costs, the Maryland General Assembly has recognized that the provision of health care encompasses more than just hospitals, and that access to quality care at an affordable price remains the single most important social issue confronting our citizens.

The Maryland General Assembly again, in 1993, has taken a bold step by enacting House Bill 1359 ("HB 1359"), a major health care reform act that builds on the tradition of the hospital rate setting system. HB 1359 creates the Health Care Access and Cost Commission ("HCACC"), and its mission is evident by its name; everyone has a right to accessible health care at an affordable price. The testimony presented herein focuses on the two agencies. The first part of the testimony describes the formation of the HSCRC as well as a summary of the rate setting system. The balance of the testimony describes the legislation creating the HCACC.

Finally, it is important to recognize the critical role played by the federal government in the success realized by our state in containing hospital costs. Maryland's all-payer hospital rate setting program, discussed more fully below, began as an experiment whereby the federal government provided Maryland with the opportunity to design a system that would produce results in the hospital cost containment area proving worthy of continuation. Maryland's proven success over the years has enabled the rate setting program to graduate from its experimental status and to serve as a model for the rest of the nation. Therefore, the enduring lesson to be learned from the Maryland success story is that given the flexibility by the federal government to be innovative, states have the ability to rise to the occasion. Now that the issue of health care reform dominates the national agenda, it is our genuine hope that the federal government will, once again, provide states with sufficient flexibility to create programs that achieve the results we all desire.

II. HOSPITAL RATE SETTING

A. BACKGROUND

As noted above, the Maryland General Assembly reacted to the skyrocketing increase in hospital costs in 1971 by creating the HSCRC, the first hospital rate setting agency in the country. Before 1971, hospitals in Maryland were reimbursed on the basis of "reasonable costs" incurred. This open ended financing system guaranteed funds for hospitals, but imposed no constraints on efficiency. With the creation of the HSCRC, hospitals were to be reimbursed based on the reasonableness of the relationship between costs and services, as determined by the HSCRC. HSCRC's rate setting methodology establishes standards of reasonableness that promote efficient use of resources.

In 1974, after three years of development, the HSCRC began performing rate reviews. At the same time, the HSCRC began negotiating with the Department of Health and Human Services for a demonstration project grant which would include a "waiver"of Medicare and

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[1] John M. Colmers has served as Executive Director of the Maryland Health Services Cost Review Commission since 1987. He was recently appointed Acting Executive Director of the newly formed Health Care Access and Cost Commission by Governor William Donald Schaefer.

Medicaid reimbursement principles in favor of HSCRC rate setting methodology. The waiver was considered essential in order to achieve the goal of equitable pricing for all-payer groups. Finally, after three years of negotiations, the waiver was granted effective July 1, 1977. As a result, Maryland became one of the first two states to establish an all-payer system. Today, Maryland stands alone as the one state in the country that maintains the equity in pricing attributable to an all-payer system. Under Section 1814(b) of the Social Security Act, Maryland maintains its waiver provided that: (1) the system remains all-payer; and (2) that the rate of increase in Medicare payments per admission in Maryland remains below the rate of increase in Medicare payments per admission nationally.

The importance of the waiver cannot be overemphasized. It is because of the waiver that cost shifting has been eliminated. Further, by regulating the entire revenue of the hospital, hospitals are encouraged to achieve greater levels of efficiency. The waiver has also fostered a stabile and predictable payment system across all sources of revenue. Indeed, with a very few set of assumptions, hospitals are able to predict their revenue stream several years into the future. As a result, these institutions can focus their attention on the expense side of the income statement, thereby enhancing their own cost containment efforts.

The cost containment features of the Maryland system has achieved dramatic results. In February of 1993, the HSCRC released its annual Disclosure Statement revealing that for the seventeenth consecutive year, the cost of a hospital admission in Maryland rose at a rate below the national average. Specifically, the cost per admission in Maryland rose 3.77%, while the national average was 8.44%. This 4.5% difference translates to savings to Maryland citizens of over $157.1 million in 1992 alone. It is noteworthy that in 1976 the cost of an admission to a Maryland hospital was more than 25% above the national average. Because hospitals have responded to the incentives provided in the Maryland rate setting system, the cost per admission to a Maryland hospital in 1992 fell to 14% <u>below</u> the national average. To put this in even clearer perspective, if costs per admission in Maryland since fiscal year 1975 had risen at the national rate, hospital costs for fiscal year 1992 in Maryland would have been $1.6 billion more than actually expended.

This cost per admission performance is even more remarkable given the fact that Maryland's per capita income is 16% above the national average (i.e., sixth highest among the states). It is important to note that these dramatic savings were achieved not in any one year but rather by surpassing the national average by 1% and 3% a year each and every year. It is also important to note that as a result of the all-payer system, Maryland enjoys the lowest percentage mark-up in hospital rates in the country. In 1991, according to statistics compiled by the American Hospital Association, the average mark-up between cost and gross charges nationally was 53%. In Maryland, the average mark-up was 14%. Thus, although the Commission does not permit discounts from approved rates unless such discounts are cost justified, payers doing business with Maryland hospitals benefit from a more equitable "playing field."

The Commission continues to monitor the financial condition of Maryland hospitals. Hospital profits increased from $58.7 million in 1991 to $108.3 million in 1992. In 1992, twenty one hospitals showed profits in excess of $2 million, while four hospitals showed losses in excess of $2 million. In total, forty acute hospitals showed profits while ten hospitals posted losses. In general, hospital profit levels in Maryland remain below national averages, as was the case prior to the implementation of rate setting. The system, however, has provided certain safeguards to assist hospitals entering the capital market.

B. <u>RATE REVIEW METHODOLOGY</u>

The Maryland rate setting system uses a quasi-public utility approach to hospital rate regulation, in which rates are set and then adjusted for such items as inflation, volume changes, and productivity gains. The Commission itself is comprised of seven part-time Commissioners, appointed by the Governor, who serve staggered four year terms. Under the Commission's enabling legislation (Health-General Article §19-201 <u>et. seq.</u>, Md. Code), no more than three of the Commissioners may be "provider" members. The Commission's

budget, which is funded through user-fees, is $2.5 million (to regulate a $4.5 billion industry) for fiscal year 1993. The Commission employs a staff of twenty-eight FTE's headed by an Executive Director.

The details of the rate setting systems are complicated, but conceptually the methods are straight forward. The HSCRC sets unit rates for each hospital department. Hospitals are required to charge those rates, and payers pay on the basis of those rates. Incentives are incorporated to reward institutions that increase productivity or otherwise lower costs. The system relies on macro-management -- that is, establishing overall constraints on hospital revenue, but allowing institutions considerable flexibility in achieving these goals. The system has as well become largely self-enforcing -- the HSCRC has conducted only one contested case hearing in the past nine years.

A complete, detailed description of the rate review methods is beyond the scope of this testimony. What follows is a brief overview.[2] Hospital rate setting in Maryland currently consists of four systems: (a) Full Rate Review; (b) Inflation Adjustment; (c) the Guaranteed Inpatient Review System; and (d) the Screening System.

1. Full Rate Review

In reviewing a hospital's request for permanent rates, the HSCRC applies a standard of reasonableness based on the experience of similar hospitals. A rate review system is used to develop an initial set of rates approved for units of service in the various revenue producing departments. The Commission lists the approved rates of the hospital under review in a "rate order", which sets forth the approved unit rates for up to fifty different revenue centers of the hospital -- e.g., the rate for a day in the general medical/surgical unit, the rate by minute in the operating room, and the rate by relative value unit in the laboratory. These rates are established initially for each hospital through a process known as a "full rate review." This process involves the evaluation of all of the cost elements associated with a particular hospital in order to determine reasonableness. Hospitals whose costs are below the peer group average -- adjusted for differences in labor costs, case-mix, teaching, etc. -- are deemed reasonable. Hospitals with costs above the peer group average are given the opportunity to justify these additional expenses, although the burden of proof is on the institution. Included in the rates approved by the Commission are reasonable provisions for capital costs including replacement cost depreciation for equipment and a capital facilities allowance for fixed capital. Every hospital in the State has undergone at least one full rate review. Most hospitals, however, have their rates adjusted each year through the Inflation Adjustment System, discussed below.

An important feature of Maryland's rate setting system is that once the Commission approves departmental unit rates, the rates are "realigned"to ensure a uniform relationship between costs and charges thereby eliminating cross-subsidization. Thus, for example, the rate in obstetrics at a particular hospital bears a direct relationship to the costs allocated at that hospital for the service. Finally, under the system all hospitals are required to annually submit data on base and budgeted years, using a uniform reporting system. The total approved revenues are based on four component parts: direct and allocated indirect departmental expenses, other financial considerations (inclusion of provisions for reasonable uncompensated care and working capital), a payor differential, and a capital facilities allowance for buildings and equipment. All in all, Maryland's rate review system provides an equity among classes of patients that far surpasses the pluralistic payment approach of non-regulated states.

2. Inflation Adjustment System

The Inflation Adjustment System was instituted to allow hospitals reasonable rate increases while avoiding the administrative burden of full rate review. It considers

[2] A more detailed description is found in A Guide To Rate Review, from the Maryland Hospital Association.

inflation adjustments, volume adjustments, changes in payor and case mixes, and certain limited pass-through costs.

Inflation adjustments are made for: 1) salaries and fringe benefits and 2) food, supplies, utilities, and other expenses. The inflation adjustment compensates the hospital for the past year if actual inflation was greater than the projected rate. (Conversely, if the actual rate is lower than the projected rate, then a deduction will be made in the budget year rate.) Second, if a correction needs to be made, a price leveling adjustment brings the rates to the level where they would have been if the inflation rate had been projected accurately. Finally, the provision for future inflation is established at a level equal to the most recent changes in inflation.

Volume for the budget year is established at a level equal to the actual volume for the current year. Different fixed-variable cost proportions have been established for the routine and ancillary areas as well as for different magnitudes of volume changes.

Pass-through costs are limited to: 1) changes in the federal minimum wage law to the extent that they exceed wage and salary allowances, 2) actuarially-supported pension cost increases (only to the extent that such increases were above the allowed increase for inflation), and 3) incremental costs resulting from compliance with requirements mandated by the Commission.

3. Guaranteed Inpatient Review System

The Commission instituted the Guaranteed Inpatient Revenue (GIR) System because of concern that the original system, based on rates per units of service, was leading to increased volume and overuse of hospital services. The GIR system seeks to control the volume of ancillaries and lengths of stay by providing hospitals with financial incentives to increase their efficiency over their own past performance. It guarantees a payment level for each case treated by the hospital. The GIR system establishes the average charge for each diagnosis for each type of payor in a selected base year. The average charge is adjusted for approved rate changes from the base year to the current period. The total GIR payment is the product of discharges (by diagnosis and payor) and adjusted charges. At year end, the GIR payment is compared to the revenue from the Commission-approved rates charged by the hospital during the year. If the revenue from rates is less than the GIR payment, the hospital will receive the fixed cost portion of the savings. However, if the revenues exceed the GIR payment, the Commission will recover the additional funds from the hospital in the following year. Another important feature of the GIR is that hospitals remaining on the GIR receive additional "new service revenue." The hospital is free to use this revenue to finance new programs and services or for any other use it deems appropriate. The amount of new service revenue provided GIR hospitals is approximately 2% a year. The Commission requires hospitals to use the new service revenue as well as productivity gains under the GIR to finance any new services and programs, thereby placing an additional constraint on rising hospital costs.

4. Screening System

The Screening System is based on a comparison of hospitals' average charge per admission after a series of adjustments for cost factors which are either beyond management control (such as labor market differences) or which the Commission chooses to finance (such as bad debt and charity expenses). This system, introduced in 1982, was designed to identify those hospitals appropriate for targeting for HSCRC rate review efforts. The Screening System also identifies those hospitals eligible for the Inflation Adjustment System. Until 1986, the comparison of hospitals' average charge per admission was done within five groups, and the cutoff point was mean plus twice the inflation factor for the particular year. Then a statewide comparison was adopted with additional regression analysis-based adjustments to each hospital's charge per admission for indirect teaching costs and the presumed cost of treating low income patients. These regression-based adjustments are similar to those used for the Medicare Prospective Payment System.

C. UNCOMPENSATED CARE METHODOLOGY

The Uncompensated Care Methodology has been developed in order for hospitals to recover their reasonable full financial requirements. As with all other components of the Commission's rate setting system, the uncompensated care provision is subject to a reasonableness standard. Since 1983, the reasonableness standard has been based upon a regression analysis conducted annually by the Commission. This regression analysis produces a predicted level of uncompensated care which serves as the upper limit in the provision of rates. For each year since 1983, one of the variables that has been used in the analysis has been the percentage of revenue attributed to Medicaid patients. The actual level of uncompensated care included in rates is based upon an analysis of the predicted amount, the actual amount incurred by the hospital, and the amount in rates, as well as the relative profits of the institution and its relative standing in charge per admission.

Notwithstanding the technical soundness of the Commission's uncompensated care methodology, the Commission has been hard-pressed to keep its adjustments within the zone of reasonableness envisioned. Hospitals' uncompensated care increased from $36 million in 1977 to $394 million in fiscal year 1992 or from 4% to 9% of revenue. The Commission believes fervently that the burden of financing uncompensated care should be distributed equitably among the various purchasers of health care hospital services. This equity can best be achieved by providing ready access to affordable, broad based health insurance to all Maryland citizens.

III. 1993 HEALTH CARE REFORM

With the enactment of HB 1359, the General Assembly has recognized that the HSCRC can only address a small portion of the problem -- i.e., the costs associated with the delivery of hospital services. In order to achieve the goal of accessible health care -- and not just hospital care -- at an affordable price, the General Assembly understood the absolute need for insurance market reform and for changes in the market for non-hospital health care services.

Like the legislation that created the HSCRC in 1971, HB 1359 also establishes an independent seven member HCACC functioning administratively within the Department of Health and Mental Hygiene. Members of the HCACC, like the HSCRC members, are appointed by the Governor. Also like the HSCRC, four of the Commissioners must be unaffiliated -- i.e., they must not have any connection with the management or policy of a health care provider or payer. The HCACC is mandated, among other things, to: (a) formulate a comprehensive standard health benefit plan ("CSHBP") as the first step in reforming the small market.; (b) establish a health care data base; (c) implement a payment system; and (d) develop cost containment strategies designed to encourage greater efficiencies in the delivery of quality care.

A. INSURANCE REFORM

HB 1359 contemplates health insurance reform in two stages: Stage 1, affecting only health insurance for small employers (those with two to fifty eligible employees), will take effect on July 1, 1994; Stage 2, affecting all health insurance (including that covering individuals and large employers), will take effect on the second January 1 following a determination by the Insurance Commissioner that at least 60% of Maryland's total population under the age of sixty-five are covered under an insured health benefit plan or under self-insured plans that have agreed to obtain insurance health benefits for their employees for at least three years. The 60% threshold recognizes the need for a large enough population base over which to spread the financial burdens associated with providing insurance coverage to every Marylander.

The HCACC is to develop (with the advice of a task force to be appointed by the Governor) specifications for a comprehensive standard health benefit plan, which carriers (i. e., those who offer health benefit plans including HMOs and non-profit health service plans),

will be required to offer. Additional benefits may be provided, but they must be offered and priced separately. Plans with less benefits than the CSHBP will be prohibited. Restrictions on coverage based on pre-existing medical conditions will be phased out. Until December 31, 1994 carriers may limit coverage, but only for a period of six months from the effective date of coverage, and only for conditions that existed within six months prior to the date of coverage. Commencing on January 1, 1995 carriers may not limit coverage for a pre-existing condition (as previously noted, this and other reform provisions will apply to individual and large-group insurance only after at least 60% of the under-sixty-five population is served.) Insurers will be required to use community rating in establishing rates for health benefit plans, and the community rate may be adjusted only for age and geography. Carriers will be required to issue health benefit plans to anyone who meets basic certain requirements (e.g., agreeing to pay the premiums).

Minimum participation requirements (e.g., 75% of eligible employees) will be permitted, but minimum employer contributions will not be. HMOs are generally subject to the same provisions, but need not offer coverage to employers or employees outside their approved service areas. Carriers will be required to renew plans at the option of the employer, with some exceptions (e.g., nonpayment of premiums), and carriers may not exclude eligible employees from a plan.

The legislation also provides for the establishment of the voluntary Maryland Small Employer Health Reinsurance Pool (in Stage 2 to be renamed the Maryland Health Reinsurance Pool). A carrier may elect to bear all the insurance risk itself or to be a reinsuring carrier. In the latter case, it will participate (for a minimum three-year period after the election) in the Reinsurance Pool, which will spread the insurance risk over a larger group of insurers, with limited exposure for individual insurers.

B. HEALTH CARE DATA BASE

The importance of establishing a comprehensive and reliable data base cannot be overemphasized. When the HSCRC was created, its most important function initially was to establish a system for the collection of data that would form the foundation for its subsequent rate review activities. To this day, the HSCRC's data base represents the lifeline to its ability to fulfill its mandate of containing hospital costs.

The medical care data base to be established by the HCACC will include information on health services rendered by all health care practitioners. The HCACC will analyze the data and annually publish the total reimbursement for all health care services, the annual rate of change, variations in fees and utilization on a state-wide basis and by health service areas. The data will also be used by the HCACC to develop cost containment strategies.

C. PAYMENT SYSTEM

The HCACC must develop and implement a payment system by January 1, 1995. The payment system provides a framework for the determination of the ultimate price for health care services. The market determines the final price of a health care service.

The payment system will be based on the following factors: the practitioner's resources (e.g., overhead, experience, expertise); the value of the service (e.g., complexity and other factors); and a conversion modifier. The ultimate price for a service will be arrived at by multiplying the numeric value of these three factors. The conversion modifier is the key to setting the dollar value of a service. The HCACC will determine the numeric value for practitioners resources and value of the service by CPT code. The market (practitioners and payers) will determine the numeric value of the conversion modifier.

The HCACC may establish health care cost annual adjustment goals for the cost of health care services and the cost for a particular CPT code. If spending exceeds these goals, the HCACC through voluntary and cooperative arrangements with practitioners may make an effort to bring spending into compliance with this goal. If these efforts prove unsuccessful,

the HCACC may adjust the conversion modifier to what it considers to be reasonable.

D. COST CONTAINMENT STRATEGIES

1. Health Insurance Cost Containment

The legislation requires insurers and health maintenance organizations to submit an annual report to the Insurance Commissioner. In an effort to establish benchmarks for efficiency, the report will provide information on their loss ratio and expense ratio for Maryland. The Insurance Commissioner may require a carrier to file new rates if: (a) its loss ratio is below 75%; or (b) its expense ratio exceeds 20% for commercial insurers or health maintenance organizations, or 18% for non-profit health service plans.

2. Malpractice Reform

In any action for damages in a medical malpractice case, the health care provider is not liable for the payment of damages unless it is established that the care given by the provider is not in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities at the time of the alleged act giving rise to the cause of action. This is more specific than the "peer standard" which has prevailed until now, and might well make it more difficult for plaintiffs to recover in malpractice cases.

3. Electronic Claims Clearinghouses

In order to decrease administrative costs, the HCACC must designate practitioners and payers who will submit and receive claims and explanation of benefits electronically by July 1, 1995. The HCACC will establish standards for the operation of one or more medical care electronic claims clearinghouses and may license such entities.

4. Delivery of Health Care Services

Health care practitioners are encouraged to voluntarily control costs by utilizing clinical resource management systems. Such systems permit practitioners to analyze their charges and utilization of services in comparison to their peers.

A fifteen member Advisory Committee on Practice Parameters will be established to study the development of practice parameters for medical specialties and make recommendations on the adoption and use of such parameters. The HCACC may adopt a practice parameter if the proposal includes supporting documentation that at least 60% of the specialists in the State affected by the parameter support the parameter, that the parameter might reduce unnecessary utilization of health care services, and that the parameter will continue to allow for the provision of a high quality of health care. The practice parameter would remain in effect for no more than three years. These parameters may serve as standard by which payers decide to what extent they pay for claims.

Any practice parameter adopted by the HCACC may not be used as evidence of the standard of care in malpractice cases.

5. Payment for Diagnostic Tests

The legislation contains a prohibition against unreasonable mark-ups by physicians of charges for diagnostic tests. If the test was personally performed or supervised by the physician, the payment is limited to the "reasonable charge," but if the test was performed by another provider or facility, payment is limited to the lower of the provider or facility's usual, customary and reasonable charge or the amount charged to the physician (plus a nominal fee for collection and handling).

As well intentioned as HB 1359 is, there, of course, is no guarantee that the legislation will ultimately achieve its purposes. Clearly, even in a best case scenario, HB 1359, in and of itself, will not solve all that may be wrong with the delivery of health care in our state. The Maryland General Assembly understood this and, therefore, enacted other provisions into law during its most recent legislative session directed at other health care related problems (e.g., patient referrals, coordination of emergency medical services, living wills, long term care insurance coverage, etc.) Thus, it does appear fair to state that HB 1359 represents one important piece of legislation which, taken in conjunction with the other measures, may well enable Maryland again to achieve innovative and meaningful health care reform for the benefit of our citizens and our health care community.

Chairman STARK. Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

I can't underscore—and I know all of us have mentioned it—but without a uniform set of data, both in terms of finances and in terms of procedures, application of benefits, none of us have sufficient headlights to see where we are going and what we are doing. All of us hope that we can get a standardized form, if we do nothing else, so that when we listen to the variety of States making statements about what it was in their particular State that did it for them, you would not have people up here, Dr. Sybinsky, saying, I know universal coverage is important, but I also think to a certain extent you have to look at the makeup of the population itself.

The mental set of people in Hawaii who understand that they either are going to sink or swim on their own—there is no neighboring State, no place somebody can drive to to resolve the problem: Diet. I have got to believe that stress factors are slightly different in Hawaii. What we would love to do is access data that would give us a profile to eliminate those factors and then agree on what the particular changes are, so that if they are not mandated, they are certainly offered and publicized. And that is one of my concerns when I look at the number of options that I see available.

It is interesting that Washington feels they have to mandate universal coverage. Minnesota knows they are going to get it anyway. Florida hopes they do. And the thing about Florida, Mr. Cook, is that when you listen to what you are talking about, there are some other things I think that need to be stressed that would have perhaps reduced the political heat of requiring universal mandate. I think you have a school-based insurance program that a lot of other States don't have. I think you have a good public health program. California does as well. And we only know what we are familiar with, and I am amazed at how other States don't have that kind of structure.

You have a number of other laws in place, such as sovereign immunity for M.D.s working in various clinics when they volunteer, to relieve the concern and other things, so that you almost have to begin looking at a much more elaborate profile of a State as to why they choose to do certain things certain ways.

And that is one of the reasons I want to stress once again that none of us here at the Federal level either appreciates or understands all of the things that are being used at the State level to meet their needs.

What I do want to ask of you in terms of anyone wishing to respond, some of you did in your testimony, that as we go forward at the Federal level, and you mentioned in Vermont, to try to move uniformly in the area of tort reform, insurance, antitrust, in trying to set up your programs you indicated, I think, Miss O'Brien, you worked long and hard with the State attorney general's office and others to try to make sure you got around the question of antitrust. I mean, dealt with it properly at the State level.

Ms. O'BRIEN. Thank you.

Mr. THOMAS. But wouldn't it be much easier for all of you in looking at remedies—and I guess the best way to ask this question is, have some of you looked at options you might have wanted to take or various folks pursued that you were precluded from doing

specifically because of your concern about running contravention to a Federal law? Anybody have any reaction?

Ms. O'BRIEN. Maybe I can just jump in, Mr. Thomas.

You are right. When we looked at antitrust we spent a great deal of time on that. We are confident and hopeful that we will be able to survive any action at the Federal level, but we felt that we needed to provide the assurances for providers to have the kind of discussions they need to have and to make the kind of plans they need to plan to form these integrated delivery systems.

It would have been much more helpful for us if the Federal Government could have done something in the antitrust area.

We did make a lot of decisions on the basis of what we perceived as potential barriers or potential places we would get into trouble as far as litigation as we crafted our plan. I think that we may have done some things differently had we not had those Federal barriers.

Mr. THOMAS. Anybody else?

Mr. SYBINSKY. I want just to talk about data. I think, going back to that, it is a very important thing we all share in common as a major need. And the other thing is to allow this experimentation to happen or allow States to move ahead in the absence of any major action in Washington.

I think we believe we have dismissed most of the categories that you have mentioned, Mr. Thomas, in your comments with data included in our testimony, but until there are other States who try to do the same things that we do and then we can test those out on a comparative data base, we will be the only folks who have taken any action. And we agree we do need more data in this regard.

Mr. COOK. Yes, sir, we would say that there is a great deal of capability today. Some of these folks have testified to you—I know they have testified to us—on risk-adjusted data. I think you can get good-risk adjusted data around——

Chairman STARK. Where?

Mr. COOK. I think Mediqual, Iameter and five or six other systems that we are looking at now for installation within our purchasing alliance will provide you with risk-adjusted data.

Chairman STARK. Prospective risk-adjustment data?

Mr. COOK. Yes, sir, I think that it is possible in at least certain categories to do it prospectively, but I think, obviously, you will have to look——

Chairman STARK. I am intruding on the gentleman's time, but if he will yield.

Mr. THOMAS. You have the button that controls the lights.

Chairman STARK. I am laboring under the impression that nowhere in the world do we know how to risk adjust prospectively, absent perhaps to 10 or 15 percent, age and sex, to some extent, but I hardly consider that risk adjusting.

Mr. COOK. Right.

Chairman STARK. I know of no evidence of any risk-adjustment plan and no insurance. It is done retrospectively, but that is just cost reimbursement. I am talking about prospectively risk adjusting. I am laboring under the assumption it doesn't exist.

Mr. COOK. No, I agree with you, Mr. Chairman, much of what we can do today is retrospective. But I think there is a great deal of work being done, at least on a marginal basis, to look prospectively at it.

Chairman STARK. Thank you.

Mr. COOK. I thought Mr. Thomas' question was——

Mr. THOMAS. Mr. Chairman, with many States pursuing different directions, we have a much better chance of getting a model that works rather than having a single program mandated from the Federal Government that somebody thinks might work.

So I am very interested as States begin to get universal coverage, begin to have structures within a general enabling ability to pursue models that somewhere somebody will do better than somebody else, and it will spread, and we will be able to come up with a better program faster.

Mr. COOK. If you could do it, sir, I think we would all like to do it. The wolf is at the door. We don't know it is politically possible, and we would indicate to you that in the absence of a public consensus on a single program that the way to go is to provide incentives for the States, provide a framework that Anya mentioned and Pete discussed, and allow us to move ahead as boldly and as quickly as we possibly today. We will move.

And the Chairman asked the question earlier of a witness about States that have not moved. My sense is that there are very few States in the country that are not moving with some speed to at least learn what they need to do to restructure their health care systems, again because they have to.

And so I would just suggest to you that what the States can do for you, with those incentives, is begin to develop the public consensus on what we should pay for, on how we should pay for it and how we should deliver it.

Ms. NIEMI. I would like to quickly respond to Mr. Thomas.

Yes, we have data collection in our bill, and we believe it is important; and, no, antitrust was not a problem. We worked on it and had a little experience with a medical antitrust suit, and the Federal statutes were not a problem.

But what I want to comment on is your comment that we were mandating coverage while other States were trying to voluntarily get people to cover. We did that 2 years ago. We got rid of all the mandated benefits. We said the insurance company can offer coverage, basic coverage, pretty much just like our basic health plan to all small businesses.

They did. They offered a perfectly affordable good package. No one would buy it. The employees made so little money, they could not pay for it and didn't want to pay for it. Most uninsured employees are working poor who are pretty young and think they are healthy anyway. The businesses just could not sell it.

Chairman STARK. What I would address to Florida and Minnesota and Vermont, I mean, the idea of what is affordable. Yes, you can put a $4,000 a year plan out there and that is access, but it leaves a lot of people still uninsured.

You can go ahead and finish, but that is a concern that I have. We can lead them to water, but——

Mr. THOMAS. I guess I am in part reacting to a sheet which has a box which says no and yes, and unless you know the experience and the support structure and the other factors involved in the State's experience, you don't fully understand the yes versus the no.

Washington State has had a particular experience. I am sure Florida, Minnesota or Vermont can tell you they are either experiencing or are having a different experience. And what I want to do is to try to figure out why some things work in some places and why they don't in others so that you can create a structure that guarantees universal coverage for everyone without dictating a particular structure in bringing it about that may or may not have worked in a particular State.

I am out of time.

I wanted to ask you about commissions. Several of you stressed, especially in the HB 1359 program, these commissions have an enormous amount of power. You have provided them with options in terms of making significant choices and directions that you go, and I am very much interested in terms of how you determine who is on them, how long their terms are, how they are elected, because that is going to be one of the battles we will have at the Federal level in terms of involving Congress directly or utilizing these commissions that, apparently, the States are finding useful and helpful.

I know the State of Washington uses a commission for everything including reapportionment and all the rest, and their answer has been commissions because they have found them successful.

So I can't do it now, but I would very much like to have specific input. If you have a commission and envision it, what are the mechanics? How are they going to be staffed? Where is the support money coming from? How long is the tenure? That sort of thing.

The other thing I cannot ask you about is a component we will deal with tangential to—I don't think integral to but tangential to—the whole health care question, and that is long-term health care. And I was curious as to what Florida and the other States have done in terms of walking through that mine field in delivering a type of a program—Hawaii as well-in terms of meeting the needs of all the people without running into the political hurdles of meeting the needs of some of the people who tend to be sometimes more well organized than others.

But I am out of time, so I can't ask you.

[The following additional information on the Minnesota Health Care Commission in response to Mr. Thomas' request is from Chapter 62J on Health Care Cost Containment in the 1992 Minnesota Statutes.]

(15) the advisability or feasibility of a system of permanent, regional coordinating boards to ensure community involvement in activities to improve affordability, accessibility, and quality of health care in each region.

History: *1992 c 549 art 1 s 3*

62J.05 MINNESOTA HEALTH CARE COMMISSION.

Subdivision 1. **Purpose of the commission.** The Minnesota health care commission consists of health care providers, purchasers, consumers, employers, and employees. The two major functions of the commission are:

(1) to make recommendations to the commissioner of health and the legislature regarding statewide and regional limits on the rate of growth of health care spending and activities to prevent or address spending in excess of the limits; and

(2) to help Minnesota communities, providers, group purchasers, employers, employees, and consumers improve the affordability, quality, and accessibility of health care.

Subd. 2. **Membership.** (a) **Number.** The Minnesota health care commission consists of 25 members, as specified in this subdivision. A member may designate a representative to act as a member of the commission in the member's absence. The governor and legislature shall coordinate appointments under this subdivision to ensure gender balance and ensure that geographic areas of the state are represented in proportion to their population.

(b) **Health plan companies.** The commission includes four members representing health plan companies, including one member appointed by the Minnesota Council of Health Maintenance Organizations, one member appointed by the Insurance Federation of Minnesota, one member appointed by Blue Cross and Blue Shield of Minnesota, and one member appointed by the governor.

(c) **Health care providers.** The commission includes six members representing health care providers, including one member appointed by the Minnesota Hospital Association, one member appointed by the Minnesota Medical Association, one member appointed by the Minnesota Nurses' Association, one rural physician appointed by the governor, and two members appointed by the governor to represent providers other than hospitals, physicians, and nurses.

(d) **Employers.** The commission includes four members representing employers, including (1) two members appointed by the Minnesota Chamber of Commerce, including one self-insured employer and one small employer; and (2) two members appointed by the governor.

(e) **Consumers.** The commission includes five consumer members, including three members appointed by the governor, one of whom must represent persons over age 65; one appointed under the rules of the senate; and one appointed under the rules of the house of representatives.

(f) **Employee unions.** The commission includes three representatives of labor unions, including two appointed by the AFL-CIO Minnesota and one appointed by the governor to represent other unions.

(g) **State agencies.** The commission includes the commissioners of commerce, employee relations, and human services.

(h) **Chair.** The governor shall designate the chair of the commission from among the governor's appointees.

Subd. 3. **Financial interests of members.** A member representing employers, consumers, or employee unions must not have any personal financial interest in the health care system except as an individual consumer of health care services. An employee who participates in the management of a health benefit plan may serve as a member representing employers or unions.

Subd. 4. **Conflicts of interest.** No member may participate or vote in commission proceedings involving an individual provider, purchaser, or patient, or a specific activ-

ity or transaction, if the member has a direct financial interest in the outcome of the commission's proceedings other than as an individual consumer of health care services.

Subd. 5. **Immunity from liability.** No member of the commission shall be held civilly or criminally liable for an act or omission by that person if the act or omission was in good faith and within the scope of the member's responsibilities under this chapter.

Subd. 6. **Terms; compensation; removal; and vacancies.** The commission is governed by section 15.0575.

Subd. 7. **Administration.** The commissioner of health shall provide office space, equipment and supplies, and technical support to the commission.

Subd. 8. **Staff.** The commission may hire an executive director who serves in the unclassified service. The executive director may hire employees and consultants as authorized by the commission and may prescribe their duties. The attorney general shall provide legal services to the commission.

History: *1992 c 549 art 1 s 4*

62J.07 LEGISLATIVE OVERSIGHT COMMISSION.

Subdivision 1. **Legislative oversight.** The legislative commission on health care access reviews the activities of the commissioner of health, the state health care commission, and all other state agencies involved in the implementation and administration of this chapter, including efforts to obtain federal approval through waivers and other means.

Subd. 2. **Membership.** The legislative commission on health care access consists of five members of the senate appointed under the rules of the senate and five members of the house of representatives appointed under the rules of the house of representatives. The legislative commission on health care access must include three members of the majority party and two members of the minority party in each house.

Subd. 3. **Reports to the commission.** The commissioner of health and the Minnesota health care commission shall report on their activities and the activities of the regional boards annually and at other times at the request of the legislative commission on health care access. The commissioners of health, commerce, and human services shall provide periodic reports to the legislative commission on the progress of rulemaking that is authorized or required under this act and shall notify members of the commission when a draft of a proposed rule has been completed and scheduled for publication in the State Register. At the request of a member of the commission, a commissioner shall provide a description and a copy of a proposed rule.

Subd. 4. **Report on revenue sources.** The legislative commission on health care access shall study the long-term integrity and stability of the revenue sources created in Laws 1992, chapter 549, as the funding mechanism for the health right program and related health care initiatives. The study must include:

(1) an analysis of the impact of the provider taxes on the health care system and the relationship between the taxes and other initiatives related to health care access, affordability, and quality;

(2) the adequacy of the revenues generated in relation to the costs of a fully implemented and appropriately designed health right program;

(3) the extent to which provider taxes are passed on to individual and group purchasers and the ability of individual providers and groups of providers to absorb all or part of the tax burden;

(4) alternative funding sources and financing methods; and

(5) other appropriate issues relating to the financing of the health right program and related initiatives.

The commission shall provide a preliminary report and recommendations to the legislature by January 15, 1993, and a final report and recommendations by January 15, 1994. The commissioners of revenue, human services, and health shall provide assistance to the commission.

History: *1992 c 549 art 1 s 5*

Chairman STARK. Mr. Kleczka.

Mr. KLECZKA. I am glad he didn't ask those questions.

Mr. Chairman, of the States that are represented here today, I note that four in our little boxes have something we call certificate of need. Something that the State of Wisconsin had some years ago. It worked to some extent, especially in the area of new surgical suites and additions to hospitals and CAT scans.

The State, for whatever reason—and I know the reason but I will not share it with you—repealed it after I left—the legislature—and now everyone has an MRI, and it is business as usual.

What has been the experience of the States that do have it as part of their system? And have you found it to be effective? Start with Mr. Cook or Hawaii.

Mr. SYBINSKY. If I might start out, our certificate of need has been in existence ever since 1974, the specific agency, and it has been effective at preventing overbuilding. We have the lowest number of nursing home beds, I think per population, of any State in the Nation, and we also have a number of hospital beds per person that is about where it should be in terms of utilization.

Mr. KLECZKA. Does it cover equipment purchases also?

Mr. SYBINSKY. Yes, it does, and I think that is the biggest problem right now.

Chairman STARK. Of course, in Hawaii the homeless are called campers.

Mr. SYBINSKY. We don't put them into our high-tech hospitals, though, and that is, I think, one of the problems that everybody faces, overbuilding those hospital beds. And that I think has been a major factor in keeping our costs controlled.

Mr. KLECZKA. Is there a level of equipment purchases; anything over $250,000?

Mr. SYBINSKY. They raised the limit about 4 years ago.

Mr. KLECZKA. To?

Mr. SYBINSKY. I think $1 million for a piece of equipment, and that has opened it up quite a bit. It is still a debatable subject because I think the technology is leaping ahead so fast the medical profession is making a great deal of demand on using it as well as they can.

Mr. KLECZKA. If we could briefly go to the other States just to get the experience.

The reason I ask the question is because every time I bring it up in this subcommittee it falls on deaf ears, but, nevertheless, I would like to pursue it. We need the experience here.

Mr. COOK. We are a bit Dickens, and like Charles Dickens said, the best and the worst of times, sir. We have the lowest nursing home rate per population over the age of 65 in the country, although we have many people over the age of 65 in our State, yet we have more MRI machines because they are not controlled, in Broward and in Dade County, than they have in the country of Germany serving 80 million Germans.

It is said that in Broward county there are only two things working 24 hours a day, some Singh stores—that is your variation of 7–Eleven and all our MRI machines.

But the extent to which——

Mr. KLECZKA. You have to pay for them somehow.

Mr. COOK. And, of course, we started our CON system after the 1970s. It was during the 1970s we went on our hospital building spree, when that was the primary form of access to elderly people.

A good friend of mine, a CEO of a private hospital in Florida with a 38 percent maximum occupancy rate—you can imagine what he charges and what he utilizes there—he says in Texas they discovered oil—he moved to Florida from Houston—he says in Texas they discovered oil under the soil and the oil industry moved there. In Florida, they discovered elder citizens, and the health care industry moved there.

We have a lot of challenges. I would suggest to you that there is a better way than CON and that is to create some form of market and to manage that market and to force people to make certain decisions.

But one thing you could do here that would be of tremendous assistance to us. Many of you all know the American Medical Association adopted a ban on physician self-referral except for a few limited circumstances. That is something you could enact at the Federal level that would have a major impact on——

Mr. KLECZKA. I would swear the chairman had that inserted in the budget reconciliation bill. You are a little late.

Chairman STARK. We snuck that in.

Mr. COOK. We need to act and pass on that, sir.

Mr. KLECZKA. The AMA followed Chairman Stark on that proposal.

OK, very briefly, because we only have 5 minutes.

Ms. NIEMI. We had your same experience. We had it, and in one way or another everybody got around it. We have the same number of MRI machines, and if they could not get around it they would appeal to the court. The judges simply didn't understand it, and they never upheld one of our CON decisions.

We pretty much did away with it except for nursing home beds, but we have restated it in this bill, and it is back in there with the commission controlling things, and it is for capital costs, I believe of over $1 million.

I was never in favor of doing away with it. I think, as many holes as it had in it, we needed something. We needed to tighten it rather than just give up.

Mr. KLECZKA. Thank you.

Ms. O'BRIEN. In Minnesota, although we don't have a specific certificate of need program, we do have a retrospective review of capital expenditures over $500,000 which was instituted last year. We have a technology advisory committee that is working and coming forward with evaluations and ways to evaluate technology, capital expenditures. Within the integrated delivery systems the plan is not that we would regulate, because we will be regulating their capitated premiums.

Mr. KLECZKA. What do you do after a review and you find a project or a cost exceeding the $500,000 is not justified? What do you do then?

Ms. O'BRIEN. The commissioner has the ability to go back in and mandate that they go through a prospective review for the following 3 years. So if they——

Mr. KLECZKA. The damage has been done.

Ms. O'BRIEN. On that particular project. But that is what we have done now.

Mr. KLECZKA. Thank you.

Ms. RADER. Vermont has a CON law. It is a fairly strict one. The threshold is $250,000. It applies to physicians' offices as well as hospitals. It is, like all CON laws, somewhat arbitrary, but I think it has been fairly successful.

We have one MRI in the State. We have a single multilithotriptor, and, actually, I think it has encouraged more mobile units than we might have otherwise had. Our biggest problem is we have a very fancy Dartmouth-Hitchcock Medical Center right across the border which is not subject to our CON law. They can put anything in it they want, and people drive over there and use the facility.

If you look at expenditure analyses in our Medicaid program or across all health care programs in Vermont you see this little blip which is the Dartmouth-Hitchcock Medical Center, where costs are much higher, and that is evidence that CON laws works.

Mr. KLECZKA. Maryland?

Mr. COLMERS. Maryland does continue to have a need program, but for hospital services it has largely become irrelevant because of the rating setting. In some ways, having a separate system looking at capital decisions without having the responsibility for financing it is like having the PTA pass on the school budget. You want to add more things yet not have the responsibility to pay for it.

In our system, CON has more exemptions than requirements. The most important exemption, however, is if a hospital agrees not to increase their rates by more than $1.5 million over the life of a project, which in a 30 year project is $50,000 a year, which is mortgage payment on some houses in Potomac. If a hospital agrees to take this pledge, it may go ahead with the project without obtaining a CON.

So we have controlled the expenditure side of it, which is really protecting the public against the costs associated with excess capacity. That is really the problem. It is not that those excess beds are unsightly, it is that they cost money. If you protect the public against that, then you allow the businesses to make appropriate decisions of when and how to enter the capital market.

We have not been that successful in the nonhospital area, although we are looking forward to the new commission to work in that area.

Mr. KLECZKA. It is an area—Mr. Chairman, thank you for the liberal use of the time—but it is an area I think we should look into. I am not very confident that competition is going to make everything more better, although in the State of Wisconsin we still have the freeze on nursing home beds, but everything else is a free-for-all.

Thank you, author of the referral language.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Clearly, I think there will be diversity permitted, probably encouraged, in whatever is proposed by the President. But I think one issue is what lessons we should learn. And as you were testifying it struck me that, in most of your cases, there is a much heavier use of HMOs than is true in most States. You talked about

80 percent in the capitated system in some areas. Is that really true? How prevalent is this?

Ms. O'BRIEN. In Minnesota right now, within our metropolitan Minneapolis-St. Paul area, the amount of managed care coverage is hovering around 55, 60 percent.

Mr. LEVIN. You say managed care because that is also used to—it applies to private insurance, fee for service with oversight. You are talking about——

Ms. O'BRIEN. Capitated managed care system.

Mr. LEVIN. HMO style.

Ms. O'BRIEN. HMO-like, although we are going to be regulating them as separate entities. They are not just strictly an extension of the HMO market. We are going to be—there are different criteria on—there will be criteria for data they will have to provide, and we have outlined that in our current statute.

Mr. LEVIN. But still you have a very high use. In Washington, it is the highest in the country is it or close to it.

Ms. NIEMI. Yes, but they can be a problem.

Mr. LEVIN. I didn't say they were not a problem. But, still, you have, what is it, over 50 percent?

Ms. NIEMI. No, it is not, but it is high. We have a very, very high group health cooperative, an HMO. And to some extent some of this reform bill was tailored to them, but that is not the answer, really. The best cost savings we achieve in the State is by the consolidated purchasing of the State, and we almost doubled that by bringing in all State employees in this, and that is where we are really going to see cost savings.

Mr. LEVIN. Then in Vermont you are talking about all Vermonters will receive their health care through an integrated system. I am not sure what that means, but you then say the integrated systems will receive a capitated payment for each enrollee?

Ms. RADER. That is a system we will have to create over the next 2 years that will require a lot of work.

Mr. LEVIN. You are requiring everything to go into a capitated system?

Ms. RADER. I think eventually there will have to be a transitional system, similar to what Minnesota is pursuing, where you have a ratesetting system for noncapitated care, and then you have the capitated care regulated through budgets.

Mr. LEVIN. You are saying all are going to go into a capitated system. I think in some States if someone in the Governor's office said that, there would be a revolution.

Mr. COOK. There would be in Florida, sir, if we said that, I can guarantee you. We had a great debate.

Ms. RADER. I think the important distinction is that the capitated payment is to the delivery system and not necessarily to the provider. The providers might be paid in a number of different manners by that integrated system.

Mr. LEVIN. All right, then. And Hawaii is still a different system, and one of the questions is how it is replicated. But let me leave that aside because that would take us a couple of hours.

Let me just ask one of the $64 billion questions around town, Mr. Colmers. Why isn't what is good for Maryland good for the Nation in terms of rate regulation?

Mr. COLMERS. As I said in my testimony, I think the most enduring lesson for Maryland is the fact that the Federal Government allowed the State flexibility. They provided us with a specific, enforceable performance standard, that is, our waiver test—if we fail the waiver test, we lose all the advantages; and the alternative is particularly distasteful to the State and to the health care community in the State—that it has forced the State to take action and successful action.

So I think you need all those elements——

Mr. LEVIN. Well, it is one of the two or three or four most controversial issues. I see the bumper stickers: Price Controls or Rate Regulation Won't Work. Now, you say it has worked in Maryland. Why won't it work in the Nation?

Mr. COLMERS. I think there are several reasons it worked in Maryland. In part, it has worked because all the participants wanted it to work. Hospitals in the State of Maryland are represented by their association, not by hospital administrators but by hospital trustees; and as a result, these are community leaders, business leaders who tend to have a different view of rising health care costs than do hospital administrators, and they have been active in supporting this.

Mr. LEVIN. We can do the same in the Nation. We can go beyond the bureaucrats.

Seriously, what are the main lessons from Maryland as to whether it would work or not work, at least on an interim basis, nationally?

Mr. COLMERS. I think that on an interim basis some form of rate control certainly could work, but I think in the long run and given the breadth of the testimony that you have heard here today, you are going to need to have a system that is going to allow flexibility to reflect the very different preferences that exist across the country.

It works in Maryland because we want it to work. If we didn't want it to work, it wouldn't be working. It is a truism, but the proof is in the pudding; we made it work here.

Mr. LEVIN. You are saying the national leadership of this country says, "First of all, the public opinion polls show where most Americans are on this subject. Most want control of costs." So why won't it work nationally?

Mr. COOK. We could give a try at that, but how difficult that would be in Florida—I would indicate to you that the ratesetting we have attempted in Congress, that I participated in when I worked on the Senate Budget Committee on various physician reimbursement systems, has had a negative effect, specifically because our physicians did not agree to it, some of our providers did not agree to it.

Mr. LEVIN. Medicare system rate regulation is not working?

Mr. COOK. We have three of the five most expensive health care cities in the country according to the Urban Institute's recent study on Medicare reimbursement. One of the reasons for that is, our utilization is extraordinarily high. Telling people how and when and where they will access their physician is a very, very difficult thing.

We had a great debate over choice in managed care within our debate in Florida, and we were forced, although we recognized the

need to do it, to provide perhaps more extended choice than we would have liked to within our networks.

I would suggest to you that unless there is a public consensus, as there was in Maryland, and a long-term historical consensus on ratesetting, you will see it going out the other end on utilization. And managing utilization is a major and difficult job.

Mr. LEVIN. Not impossible.

Mr. SYBINSKY. If I might also note again, the differences between the Hawaii system and the system in Maryland, I think there is a comparison that we have controlled our costs in Hawaii with low insurance rates for everybody who is buying insurance in the State. Those low rates are an indicator of the fact our system is controlling costs through pure competition, managed basically by the fact that there are a limited number of insurance providers and that everybody has to be covered with insurance.

So our approach is different from that of Maryland, but we think our outcomes are about the same, good low costs.

Mr. THOMAS. Would the gentleman yield on that, because the gentleman from Hawaii just mentioned outcomes.

The lady representing the Governor of Vermont mentioned outcomes. I don't understand why you have this strong compulsion to force everybody into a particular structure, when if we talk about how much it is going to cost and what benefits are going to be provided and what outcomes are to occur, that you need to get inside the black box and make sure that it is wired just the way you want it wired. I think——

Mr. LEVIN. Whose compulsion? I don't have any such compulsion at all. It is Vermont that is, according to the testimony, saying all shall be within a certain kind of system, not me.

Mr. THOMAS. But that is Vermont who wants to say it that way. And if Minnesota wants to say it differently, I believe our responsibility should be universal coverage in terms of uniform package, financed federally, with an understanding of what we want as the end result. And if we try to dictate everything in between that, one, we won't get it; and two, it won't be in place in time to save any of these people's jobs, I know for sure, and probably not ours either.

Mr. LEVIN. No, I am not sure what the differences are here, but unless it is clear that we set some limits on cost, diversity won't work.

Mr. COLMERS. I think there is no disagreement on that. Costs clearly have to be controlled and there are a variety of ways of doing it. Our approach is the one we think works in Maryland, but there are other approaches.

Mr. LEVIN. And other approaches, and let no one say one is necessarily more rigorous than another because the Vermont way, it strikes me, is the, in a sense, the most rigorous. We can control costs in this country if we say everybody will join an HMO of their choice. We will control costs probably, but there is much less consensus for that than there is for giving people a choice with some kind of a cost framework that is operative.

Mr. THOMAS. If the consensus is in Vermont for that; if there is a different consensus in Minnesota, that is fine. I would rather drive to a consensus on a State level than on a national consensus because you are not going to get it.

Mr. LEVIN. I agree with that. We didn't settle it here, though.

Chairman STARK. I want to ask Dr. Sybinsky, with your competitive model, if you were to have to operate under a global budget and you went, say 10 percent over it, for whatever reason, how would you bring it down? How would you get it into balance?

Mr. SYBINSKY. First, Mr. Chairman, I have great confidence we would not go 10 percent over.

Chairman STARK. I understand that. We all have that confidence in you, too. But if you did, you don't have a mechanism or a law that could force it back into compliance, do you?

Mr. SYBINSKY. We would then deal with the problem.

Chairman STARK. Would pass a law.

Mr. SYBINSKY. We would pass a law to deal with it.

Chairman STARK. All right. As I say, I hope you never need one, but you might.

I guess what I would suggest to the witnesses, and I would like to see how this would fit within each of your States. Mr. Cook, I would suggest to you that in Medicare, even in Florida, the physician utilization was held down this past year. It did not go up as high as the targets. It was well under the targets for both primary care and surgeons. As a matter of fact, much to my disbelief, the American Medical Association just announced that they would favor a nationwide RBRVS system for private pay. Now, they didn't want anybody setting the index, as we do for the Government rate.

But I am suggesting to you the idea of a rate structure, which is what would happen to Maryland, God forbid, if they lost their exemption. So what I have suggested many times is that we have, for better or worse, in place a ratesetting structure for physicians and for hospitals and for HMOs as a practical matter.

Now, what would be wrong and why would the States all fall on their swords if we said, all right, States—as we have said to Maryland—here is your budget, approximately what you are spending now, and we will let you go up at CPI plus a point or two but no more? Now, if you go above that, then you are under our rates and you lose your exemption and you get the HMO rates and the fee-for-service rates that are structured federally.

Can Hawaii live with that?

Mr. SYBINSKY. Mr. Chairman, I think the one thing, I think we would have to put as a caveat—because basically I think we could—would be that there would be adequate data collection available so that we could measure this stuff, and I think that would be fair.

Chairman STARK. Well, you wouldn't have to measure it. All you get is a gross dollar amount. It is up to you. You get *x* bucks a year and one number. If you can come in under it, God bless you.

Can Florida live with that?

Mr. COOK. Sir, I would like to see you and raise you one. I think we can do better than that.

Chairman STARK. Well, then you would be exempt.

Mr. COOK. What I would suggest to you is that if you establish a national health care board, that the national health care board negotiate State by State.

Chairman STARK. You are talking to it right now. You are not about to see a national health care board.

Mr. COOK. The challenge I would suggest to you is that States do differ. There is extensive profiteering in some States.

Chairman STARK. That is exactly what I said. I said, you go ahead and do whatever you want, but if you don't——

Mr. COOK. You might want to cut my costs more than that, sir. You may want to go into my base.

Chairman STARK. The idea of the plan, as we do it with Maryland, is if you save the money, you get to keep it and spend it. Build some new roads, for all I care.

Mr. COOK. Could you set up better incentives than that, sir? To the extent that we exceeded our target or came below our target, could we keep more?

Chairman STARK. Now, don't get greedy. I am just saying——

Mr. COOK. We just think a system of incentives like that and negotiation like that, as we would negotiate with these health partners, might yield a better——

Chairman STARK. You are going to need Ira Magaziner down there to help you.

Senator, could Washington?

Ms. NIEMI. If you are suggesting a waiver of sorts, you give us the money, and if we cannot live with it, then we go under a rate structure, sure, we can live with it. I am sure we can do well with the money you give us and will go under the rate structure. But of course——

Chairman STARK. How would you do it?

Ms. NIEMI. The way we do now.

I love this emphasis on flexibility that I am hearing here. We can manage very well if we get that amount without having to follow specific guidelines.

Mr. THOMAS. Mr. Chairman, you folks can continue to play this game, but if you heard him, there is no national health board; it is going to be Congress that sets it. And if you believe you are going to get money without an attachment of who, what, when and how—we can continue to do this all the way through the lunch hour, but let me tell you, that is far more a fantasy world than the Government dictating structure.

Mr. LEVIN. You said you wanted national standards.

Chairman STARK. Maryland gets it now.

Mr. THOMAS. Yes, in terms of a waiver in which——

Chairman STARK. Reclaiming my time, I am not suggesting for a moment that we are necessarily going to preempt employees' responsibilities or anything else. I am suggesting we may have to continue to pay for the impoverished because many of the States, Hawaii excluded, but Florida, Minnesota, Vermont and Maryland really don't have guaranteed access in coverage.

Mr. THOMAS. I understand that, Mr. Chairman.

Chairman STARK. To that extent, the Federal Government would have to provide some kind of a plan.

Mr. THOMAS. And if the gentleman would yield, I certainly don't have a prospective ability to examine this, but I have seen recent models which indicate that we will provide money initially, and then we will provide a series of mandates with no additional money; and you will be required to perform far beyond with less

money than you ever anticipated. And that is what will happen. Not to predict.

Chairman STARK. How would Minnesota——

Ms. O'BRIEN. Minnesota would feel, given our past history, we could compete with the other States. And we are containing costs. Our per capita costs are 15 to 18 percent below the national average without rate regulation.

Chairman STARK. And you could put that in pocket.

Ms. O'BRIEN. Again, we would be concerned about the mandates and requirements from the Federal Government. We continue to be concerned about that. We usually exceed those mandates.

Chairman STARK. Let's take Medicare, for example. They are the mandates. That is what Maryland lives with. They are not so onerous. The whole country has to go along with them. They are probably a third of your medical now; probably 40 percent in Florida. Seem to work all right. And there are not any of our seniors that will voluntarily get out of it.

Ms. O'BRIEN. Our Medicare reimbursement rates are a little better now, but historically have been some of the lowest in the Nation because of our low utilization and our conservative style of medicine.

Chairman STARK. God bless you.

Ms. O'BRIEN. And if we continue to be penalized because of our low utilization and our conservative style of Medicare containing costs——

Chairman STARK. Suppose we give you the average.

Ms. O'BRIEN. If you give us the average, Mr. Stark, we will do fine.

Chairman STARK. Florida would go broke but you would do well.

Ms. O'BRIEN. We would do just fine, then.

Chairman STARK. Vermont.

Ms. RADER. We would gladly take the average.

Chairman STARK. That is what Maryland has stayed below, so it works there.

Quite frankly, you all are the premier States—California couldn't come close. We have fairly good testimony, even with our bellwether CalPERS plan. The only reason major insurers there were able to stay in line is because they cut benefits, and that is easy to do. The cheap shot is just up the copays.

What are those of you who don't now have complete access—Florida, Minnesota, Vermont and Maryland—Washington has an individual mandate. What does that mean? How do you mandate me as an individual?

Ms. NIEMI. Yes, that's pretty funny. Someone suggested we have a criminal penalty if you didn't buy it.

Chairman STARK. I like that.

Ms. NIEMI. It didn't go very far. It means we expect everybody to pay a part of this. Copays, total premium cost if you are self-insured. Of course, with an ability to pay.

Chairman STARK. Let me give you the person that falls between the cracks in all your States. This is sort of akin to Reagan's welfare cheat in her urban cape with a handful of food stamps.

It is a single mother who is 35 years old and has three jobs, all with scruffy employers; the worst of which is Nordstrom, who has

made an art form out of keeping people in part-time employment without giving them benefits.

Ms. NIEMI. I agree with you totally. I suspended my charge card.

Chairman STARK. The worst is McDonald's. She works there for a while, and then on weekends she is on a wait staff of a food service establishment, as they would call themselves, who suggest they could never afford to pay minimum wage increases or health care.

So she works three jobs and manages to come in with that probably just under two times the poverty level and gets a lot of that eaten up with day care. She doesn't get into the system, maybe under SHIP, but I don't know how much she would pay. But do her employers for hourly basis have to contribute? Do they have to kick in or do they get off free?

Mr. SYBINSKY. No. When the director of health in our State raised that question once, he got a storm of letters from all the employers.

Chairman STARK. So they don't kick in, but you do. You subsidize those employers who are not doing the right thing?

Mr. SYBINSKY. We would subsidize—as far as the part-time employment, it is a very difficult thing to enforce, and so that is why we went to the simple model of offering people under 300 percent of poverty a gap group insurance program.

Chairman STARK. Do you have a minimum wage law in Hawaii?

Mr. SYBINSKY. Yes.

Chairman STARK. Higher than $4.25, isn't it?

Mr. SYBINSKI. $4.75.

Chairman STARK. Why is that hard to enforce? What if you kicked that up an extra 50 cents an hour and made it a minimum wage benefit. Anybody who has a full insurance program doesn't have to pay the extra 50 cents. They could collect it that way.

Mr. SYBINSKY. That is a thought.

Chairman STARK. Not a bad idea, is it? Just remember where you got it. Invite me over and I will come testify.

Mr. SYBINSKY. I will look into that, Mr. Chairman.

Chairman STARK. How will you pick up these folks in Florida, for instance?

Mr. THOMAS. If the benefit package was 50 cents an hour, we all would not all be here talking about needs.

Chairman STARK. No, no, I am just saying that is $1,000 a year. That will buy——

Mr. THOMAS. It is five times the cost of the 50 cents.

Mr. COOK. We would hope our Medicaid buy-in program would pick up those folks.

Chairman STARK. Which kind?

Mr. COOK. What we call our Medicaid buy-in program. It is our employer subsidy, and it is what we have suggested to fund the gap group. We have talked to your staff about it, but a brief explanation of it is that we would cover those people up to 250 percent of the poverty level; the Feds would pick up the first half of that, as they do in most Medicaid programs; States would then pick up half of the remaining half, with that 25 percent divided between employer and employee.

Right now, when you get to your affordability question earlier, the average Medicaid package for a family of four in the State of

Florida is about $4,800 a year. If the Feds picked up $2,400 of that, if we picked up $1,200 of that, that would leave $600 apiece for employers and employees, that is $50 a month. And according to the Robert Wood Johnson Foundation's work with us, that is about the place where you get employers in.

Mr. THOMAS. Those numbers I will buy.

Chairman STARK. I would tell you the stories that the NFIB gives us where in one recent test, where they polled their members and asked would you be agreeable to providing health insurance to all your employees, even if you didn't have to pay any of the cost, 62 percent said no. So, so much for the conscience of our faulted small business community in this world and what they will do for social justice.

Mr. COOK. In fairness though, sir, to the NFIB, and they have opposed many of the measures we have tried as an institution, although they favored our health care reform bill——

Chairman STARK. Because it didn't cost anything for them. Of course they will.

Mr. COOK. Sir, I think they believe it will cost them something, because we certainly have been frank with them that over time we don't believe that you can cover everyone without a mandate. But, frankly, we don't believe you can pass a mandate without a subsidy in a major State with a major number of uninsureds, and you have to find a way to bring people into the system.

These people are working on the narrowest of margins, and without a mandate, they will lay off employees, or without a subsidy, they will lay off employees. We have to find a way to communicate and work with them.

I don't think it is their conscience; I think it is their fear and their pocketbooks that drives them.

Chairman STARK. I am sure it is their pocketbook.

How do you——

Ms. NIEMI. We did not solve that. That is one of the things we just could not solve.

Chairman STARK. I like that term "resident." I used to say "socialize the benefit," but you say "residency benefits."

Ms. NIEMI. That seems to goes down a little easier than single-payer. Single-payer makes it sound like the Government is going to control it. And as a matter of fact, we can contract out managing health care cost. It doesn't have to be the Government.

Chairman STARK. How do you deal with the illegal alien problem when you say "resident?"

Ms. NIEMI. Legally, in my opinion, they are residents, and we pay.

Chairman STARK. Canadians all look like Washingtonians anyway.

Ms. NIEMI. They have a better system. They like their system better.

Chairman STARK. I understand that.

Ms. NIEMI. There has to be some utilization payment on behalf of the employee, but beyond that we have to subsidize; and that is why we have to get everybody in the pool.

Chairman STARK. So if you made it resident-based and made the employers only responsible for a financial contribution but not the benefits, you would have what you want.

Ms. NIEMI. That is true, about 7 percent.

Ms. O'BRIEN. In Minnesota, that individual would be eligible for the Minnesota subsidized plan which goes up to 275 percent of poverty. It is a rising contribution that the individual makes as they go up the income level, but it is based on both income and family size.

Chairman STARK. Who would they get the insurance from?

Ms. O'BRIEN. The State.

Chairman STARK. The State actually?

Ms. O'BRIEN. Through the MinnesotaCare subsidized——

Chairman STARK. It is a pool.

Ms. O'BRIEN. It is a pool, and we are consolidating all State health care purchasing into one pool, so it will be consolidated with the medical assistance program with the State employees health program.

Chairman STARK. Now, our State employees—gorgeous folks that they are—just raised hell when they thought the CalPERS system would see the Medicaid beneficiaries blended into that. They practically started a revolt.

Ms. NIEMI. We did that but they didn't like that.

Mr. THOMAS. Is the gentleman suggesting that perhaps the motivated State employees have similar concerns as the National Federation of Independent Business when 62 percent said they didn't want to be——

Mr. COOK. Our State employees, sir.

Mr. THOMAS. I think when we get into trying to determine motives, most of it will boil down to cost. To place the motive of someone not wanting to have an employee or someone else not have medical benefits, the State employees are concerned that what they have will be diluted.

Let me tell you, anybody who has the benefits those folks have, if we are going go to universal coverage and be able to pay for it, they are going to have to have their plans diluted to a certain extent.

So when we talk about motives, I really think we should spend time on figuring out how to pay for it, how to figure out what the cost benefit package is, try to create enabling legislation at the Federal level so you folks can get out there and do what you need to do as rapidly as possible; and most important of all, get some kind of standardization in terms of what we are looking at, both in terms of the cost side and of the service side, so that we can start doing what works rather than spending all of our time talking about what we think works.

I thank the gentleman for the time.

Chairman STARK. How is Vermont going to get all the folks in?

Ms. RADER. First of all, we would already likely be covering the children of that individual at this point in time.

Chairman STARK. Have you socialized the benefits for all children in Vermont?

Ms. RADER. Up to 225 percent of poverty through age 17.

Mr. THOMAS. You have personalized it.

Chairman STARK. So how do you provide the insurance for those?

Ms. RADER. Through our Medicaid program.

Chairman STARK. Through Medicaid. So you have expanded the benefits and you pick that up yourself. And where are your payments to providers relative to Medicare?

Ms. RADER. They are lower.

Chairman STARK. Much lower?

Ms. RADER. Not as bad as some other States but lower.

Chairman STARK. You don't have an access problem.

Ms. RADER. We do in certain specialties, and, in fact, as a result of our expansion of the children's program we had to raise our pediatrician fees starting June 1.

Chairman STARK. Good for you.

Ms. RADER. And also pediatric dentistry because it covers dentistry also.

In terms of how we would cover that individual in the future, as I said, we have two plans under consideration, the first which is the Governor's preferred plan, would separate her coverage from employment. That would be the simpler way of doing it. But I don't know if, A, it will be politically feasible in our State, and, B, it will fit with the national framework.

The second plan, the employment-based plan, would require some sort of other program to pick up her coverage.

Chairman STARK. What about providers?

Ms. RADER. We have one doc there now, and there will always be one. We will likely have a number of different types of integrated systems and a handful that are either covering a part of the State or all of the State.

Chairman STARK. And you will not allow someone to practice outside of those?

Ms. RADER. That is an outstanding question. I think it is likely there will be a—like on the regulatory side—there will be a transitional program where there is a ratesetting system. I think it is likely there will be a transitional system.

Chairman STARK. Do you have many HMOs in Vermont? Any?

Ms. RADER. At this point, we have one that is active.

Chairman STARK. Burlington?

Ms. RADER. Burlington.

Chairman STARK. Staff model, do you know?

Ms. RADER. Part of its business is staff model, but the bulk of its business is not.

Chairman STARK. Has it been there a long time?

Ms. RADER. Probably about 10 years, and two others that just entered the State.

Chairman STARK. Is it popular?

Ms. RADER. It is very popular. Buying up practices like crazy. Getting new, young, healthy customers like crazy.

Chairman STARK. Where are the older sick customers?

Ms. RADER. They are in our plan.

Mr. COOK. They are coming to our State, sir.

Chairman STARK. Nobody has brought up risk selection here today. You guys are all just smiling and thinking that ain't going to happen.

Hawaii, you have a lower percentage of people in HMOs than a fee-for-service in Hawaii. Why is that?

I keep hearing these guys over at the White House tell me about how all the people in the country are going to flock to HMOs. Well, in areas where there is a choice or in areas where they give you a free chicken dinner for everybody that will come to the tent and listen to the sales pitch they don't sell so well. Why not in Hawaii where you have had Kaiser forever, almost as long as Harry Bridges?

Mr. SYBINSKY. In Hawaii, essentially the strict HMO is about 23 percent of the population. But I think you are referring to the fact that our largest insurer, which has over half the market, has a real good—does a real good job of cost control largely through setting fees for doctors and making those fees stick. And so, basically, a lot of the people are in managed care system any way.

This year, they announced the largest portion of their business is now preferred provider organizations.

Chairman STARK. The Blues?

Mr. SYBINSKY. Yes.

Chairman STARK. And you only have half a dozen major hospitals that cover the whole State. Right?

Mr. SYBINSKY. We have approximately 12 major hospitals, 2 of which are State-owned and 9 of which are private nonprofit.

Chairman STARK. What is Maryland going to do? Are you going to be able to close the loop and do the other half of the circle?

Mr. COLMERS. I will tell you the answer when I get the data. The data is critically important. I don't think we have reached a consensus or a decision how we will do it.

Chairman STARK. I have to tell the rest of the witnesses that this guy is going tomorrow to China to set up their hospital payment system. He is going to become Commissioner Colmers. Anything he says will happen or they will take him into Tiananmen Square and string him up. That is the way to get things done.

Mr. COLMERS. Actually, the hospitals have told me I am going to teach the commies how to regulate. They have lost their touch over the years.

I think the answer of how we do it will depend so much on the data. There is a lot of mythology out there as to who the culprits are. We have learned on the hospital side than you cannot come up with a solution until you have an accurate and timely data base.

So much of the debate will just be pure rhetoric until you can sit down across the table with people with hard numbers that is, in fact, their numbers so that, if they complain about them, you just turn to them and say, well, it is what you gave me. You cannot complain about the data. It is your data. It will have to wait until we get that, and we are working hard to get that quickly.

Chairman STARK. What do you think you will do? What do you guess will evolve out of this? When you have the physician data, you don't have a lot of HMO presence.

Mr. COLMERS. We actually have a fairly high HMO penetration in Maryland, among the highest in the country in part because of the large number of Federal employees in the Washington area.

What the legislation envisions is a payment system being developed by 1995 that is not enforceable at first, but it does set common ground rules for the payment, basically along the lines of the RBRVS system. It is CPT based. It has a relative value scale. There is a level of effort and intensity adjustment and, finally, a payment adjustment at the very end which makes up the difference between those factors and what people end up getting paid.

And, for the first time, we are going to really see levels of payment across specialty, across individual physicians, the broad variation that exists between charge levels and payment levels by a CPT level, and I think that will be very revealing. What we do with that once we get the information, as I say, is premature to talk about, but it will be fascinating certainly.

Chairman STARK. Well, as has been this session.

I want to thank all of you. It is a matter of some interest, if not concern, what we will be doing, but I do think we will make an honest attempt to set a Federal benefit standard so that at least you have a basis on which to argue and battle. And my hope is that we will find financing. I don't know that many of us are going to be content to just collect taxes in your State and then turn them over to some ill-defined HIPC.

Have any of you seen one? You have them. You have a law in Florida. But do you have a HIPC?

Mr. COOK. We appoint our first one in about 2 weeks.

Chairman STARK. I would love to see it. Do you have the rules for it?

Mr. COOK. We have to publish the rules when we appoint it. We call them CHPAs not HIPC.

Chairman STARK. A unicorn is a unicorn.

I would love to see a copy of your rules. It will be an interesting couple of years as this stuff unfolds.

I appreciate all the work all of you are doing and appreciate your help. Thank you very much.

[Whereupon, at 1:05 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement Of The American Medical Student Association

SUBMITTED TO THE

SUBCOMMITTEE ON HEALTH

OF THE COMMITTEE

ON WAY AND MEANS,

U.S. HOUSE OF REPRESENTATIVES

THE STATE ROLE IN HEALTH CARE REFORM

By Suzanne El-Attar, M.D.
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June 22, 1993

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Perspective Of Tomorrow's Physicians

The American Medical Student Association (AMSA) is an independent national organization representing more than 30,000 medical students and residents nationwide. Speaking for its membership, AMSA offers the following comments on state responsibility and involvement in health care reform.

As we patiently wait for the Clinton administration to propose legislation to reform health care in this nation, more than half of the states are deliberating health care reform plans of their own. Currently, eight states, Florida, Hawaii, Maryland, Massachusetts, Minnesota, Oregon, Vermont and Washington, have enacted such legislation. It is evident many states believe health care reform is their responsibility, while others are willing to wait for federal legislation.

AMSA commends these independent efforts by the individual states to improve their health care systems. However, there is concern for how effective state health care reform will be without federal involvement. The current health care system and many of its problems are the result of both federal and state regulations and policy. I will take cooperative and collaborative effort on the part of both levels of government to enact effective, comprehensive reform.

STATE ADVANTAGES AND CAPABILITIES

1. **Better ability to assess local needs**
   One of the major concerns of a federal plan for health care reform is its possible inability to determine and affect varying local health care needs. Many of the federal perspectives of current health care problems are based on national averages. These averages may reflect the needs of a majority of states, but may miss the mark on a significant number of other states.

2. **Regulatory controls of the health professions**
   States have the major responsibility to license and regulate the health professions. These regulations include determination of practice acts and prescriptive authority for these providers. They also finance and administer the educational programs for them. The federal government has a minimal role in these policies.

3. **Capability to enact health care reform legislation**
While health care reform legislation has been faced with the same lobbying efforts and political arguments at the state level as at the federal, some states have been able to overcome these barriers and enact legislation. The smaller political and financial size of the states probably has significant impact on this ability. States also have a better chance of creating public support for a plan that is tailored to the local need. Whatever the reason, currently, the states have shown a level of commitment and ability to work cooperatively the federal government has been unable achieve.

STATE BARRIERS AND LIMITATIONS

1. **Federal subsidization of third-party insurance**
The federal government subsidizes employers who provide health insurance to their employees with generous tax breaks. The employees also benefit from income tax breaks for their share of the insurance cost. These tax reliefs are not available to individuals who pay for insurance out-of-pocket. Therefore, it is more expensive for the self-employed, the unemployed and employees of small companies that do not provide health insurance to purchase the same coverage provided by the larger employers. If a state plan eliminates employer coverage, the states would then have to incur the health care costs provided by these federal subsidies.

2. **Medicare**
This coverage for the elderly and disabled is fully funded by the federal government. Health expenditures by the elderly and the disabled account for about 30% of all acute care spending and this amount continues to increase. Any state plan modifying or dissolving Medicare, would have to receive a federal waiver and once again states would incur significant health costs.

3. **Medicaid**
This joint federal-state program, contains many federal restrictions that limit state options. The difficulty in obtaining a federal waiver is depicted by Oregon's health care reform attempt. When Oregon was initially denied the waiver, the power of the federal government over a state's ability to reform health care became evident.

4. **Employment Retirement Income Security Act**
   ERISA has provisions that effectively shield employers who self-insure from state regulations. States are precluded from regulating benefits or assessing taxes on health care coverage provided by businesses who choose to provide their own insurance. This is yet another federal regulation the states must overcome.

5. **Potential loss of jobs or population**
   Some states have attempted an increase in taxes for individuals and businesses to help finance health care reform. These taxes would need to be even more substantial for poorer states to afford reform. There is concern that residents and businesses who oppose these taxes may move to neighboring states that do not impose these added taxes. The most significant fear is the loss of jobs a state would face if a business were to move.

   Another reason individuals may leave a state is due to varying benefits packages. A resident may be forced to move to a new state that insures a service of need not covered in the home state.

SOLUTION

The main limitations the states face in producing health care reform that ensures universal coverage, quality and cost containment are significant financial limitations and federal regulatory barriers. The states have the better ability of assessing the health care needs of its residents. AMSA supports the development of a national health program in which the federal and state governments both have a substantial role. This program would be based on a single-payer system and cover a comprehensive list of services.

The federal government would have several responsibilities. First it would be the major financial support for this plan. The states are very limited by finances. Currently, the federal government uses a variety of sources to cover a large amount of the nations health care costs. These sources could be consolidated into a single pool for ultimate disbursement to the states.

The next responsibility of the federal government would be the development of a benefits package. AMSA supports a comprehensive package with emphasis on ambulatory and

preventive care and the inclusion of mental health and abortion services. This package would be mandated to each state as the minimum of coverage.

The third responsibility of the federal government would be the removal of the restrictive regulations prohibiting effective delivery of services. The states would be given more latitude in implementing health care reform as long as they abide by national regulations such as the minimum benefits package and universal access.

State responsibilities would include financial support for the plan. There are currently state supports for health care that could be included in the single pool of health care funding.

The main responsibility of the states would be the implementation and delivery of health care services. They would be responsible for assuring quality delivery of care to all citizens. The states would remain the major regulators of the health professions. The implementation of the health system would most likely be tailored to the local needs of the state be it rural, urban or underserved.

Under this plan, states would not have to be concerned about the loss of jobs or population. This is because all states would have the same minimum benefits package and similar financial supports. The incentives for individuals or businesses to leave a particular state would be removed.

CONCLUSION

AMSA is deeply committed to health care system which provides affordable, quality health care for all. The states must play a significant but not independent role in this reform. AMSA supports the development of a national health plan in which the state and federal governments work cooperatively to achieve common goals for the entire nation. The American Medical Student Association would welcome the opportunity to discuss these issues further with you.

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STATEMENT FOR THE HEARING RECORD
SUBMITTED BY MARK J. UGORETZ, PRESIDENT
ON BEHALF OF
THE ERISA INDUSTRY COMMITTEE

"HEALTH CARE REFORM: STATE HEALTH REFORM INITIATIVES"

HOUSE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

JUNE 8, 1993

The ERISA Industry Committee (ERIC)

ERIC represents the employee benefits interests of the nation's largest employers. Virtually all of ERIC's members employ more than 10,000 employees, and a number of them have hundreds of thousands of employees. As sponsors of health, disability, pension, savings, life insurance, and other benefit plans covering approximately 25 million participants and beneficiaries, ERIC's members have a strong interest in the success and expansion of the employee benefit system in the private sector.

All of ERIC's members do business and provide health and retirement plans in more than one state, and some have operations and employees in all fifty states. Transfers of employees from one state to another are common. The plans sponsored by ERIC's members generally provide uniform benefits in all states where beneficiaries are located. Nationwide benefit uniformity reduces plan costs, reduces the contributions that employees and employers must make to finance their benefit plans, and enables a multi-state employer to devote a higher percentage of its benefit budget to benefits rather than to administrative expenses.

ERIC members sponsor benefit plans that set the standard for comprehensive employment-based health care coverage. All of ERIC's members provide comprehensive health care coverage to their employees. Together, they provide coverage to approximately ten percent of the U.S. population.

ERIC'S POSITION ON HEALTH CARE REFORM

ERIC recently published its *Policy Statement on Comprehensive Health Care System Reform*, which we are pleased to submit to the Subcommittee for the record together with our written statement. The *Policy Statement* reflects broad consensus within ERIC's membership on the following general principles of health care system reform:

- ♦ A public-private partnership encompassing payers, providers and patients to design and implement reform;
- ♦ A comprehensive strategy for making the health care system coherent, efficient and cost effective;

- An opportunity for employers to voluntarily continue to be the primary source of health care coverage for their own employees and their employees' dependents; and

- Federal leadership in establishing a national health care policy.

It is significant that the general principles include the following two requirements for health care system reform:

First, health care system reform must be comprehensive rather than piecemeal.

Second, health care system reform must be carried out pursuant to a comprehensive federal policy.

ERIC's *Policy Statement* concludes, and our members strongly believe, that America's health care system can become coherent, efficient, and cost-effective only if reform is carried out pursuant to a comprehensive federal policy rather than as the result of diverse state action. The *Policy Statement* states that the absence of a coherent national policy, the encouragement of state experimentation or reliance on other piecemeal incremental approaches are likely to further fragment the health care system and increase costs.

ERIC OPPOSES PROPOSALS TO UNDERMINE NATIONWIDE UNIFORMITY

ERIC opposes legislation such as that would undermine ERISA preemption of state laws relating to employer-sponsored health plans. Such legislation is fundamentally incompatible with comprehensive health care system reform in accordance with a coherent national policy. If enacted, the legislation will be a step backward, not forward, on the road to reform.

WEAKENING ERISA PREEMPTION WILL TURN BACK THE CLOCK ON LANDMARK FEDERAL REFORM LEGISLATION.

The enactment of ERISA in 1974 was a milestone in reform of federal employee benefit policy. ERISA established uniform federal standards for a broad range of employee benefit plans, including health plans.

ERISA regulates the pension, health, and other welfare benefit plans that employers establish for their employees, and treats employee benefit plans as exclusively a federal concern.

Prior to the enactment of ERISA, employee benefit plans were regulated by a patchwork quilt of state statutes and state common-law rules. An employer that sought to maintain a uniform employee benefit plan for a multi-state workforce encountered severe administrative difficulty and expense in complying with rules that differed from state to state. The employer often was prevented from providing its employees with the best possible benefits at the most reasonable cost. Often employees transferred from one state to another encountered difficulties in carrying with them the same coverage and benefits on which they depended.

In recognition of the hardships and inequities that employees and employers suffered under state regulation, Congress included in ERISA a broad provision

preempting state laws relating to employee benefit plans. The legislative history of ERISA confirms what is clear from the plain language of the statute itself: that Congress intended to preempt state laws that apply to all ERISA-covered benefit plans, including health plans.

ERISA's preemption of state laws that relate to employee benefit plans is essential to the fundamental policies of ERISA and the effective administration of voluntary employer-provided health care coverage. ERISA provides national uniformity in the regulation of employee benefit plans and promotes the growth and soundness of these plans through exclusive federal regulation under a unitary legal regime.

If states are permitted to enforce a crazy-quilt of laws against health plans, employees and employers alike will suffer. Employers will reduce the benefits that their plans provide in order to keep costs at acceptable levels. Employees, who generally contribute to their employers' health plans, will find that their contributions will increase, that their benefits will be reduced, or both.

ERISA preemption thus encourages both employees and employers to achieve the best possible benefits at the most reasonable cost, and thereby advances a fundamental reform made by ERISA: national uniformity in benefit-plan regulation. That reform is responsible for the substantial employer support for health benefit coverage: today approximately 150 million employees and their dependents are covered by employer-sponsored health plans.[1/]

THE NEED FOR HEALTH CARE REFORM IS A NATIONAL NEED THAT REQUIRES A NATIONAL SOLUTION.

There can be no doubt that the U.S. health care system has serious problems. Each year billions of dollars in health care expenditures are wasted on inappropriate or poor quality health care. The rapidly escalating cost of health care has forced both private and public payers to reduce coverage, shift costs to other payers, or require individuals to assume a greater share of total costs. Cost-shifting among payers has exacerbated the increasing cost of health care for most payers, which has further eroded coverage. As a result, millions of Americans lack reasonable access to basic health care or lack the financial resources to obtain care, except through inefficient settings such as hospital emergency rooms or through already overburdened public health clinics.

In 1990 the nation spent over $666 billion on health care, equal to 12.2 percent of our Gross National Product. These figures are projected to increase: to $1,073 billion and 14.7% of GNP in 1995 and $1,616 billion and 16.4% of GNP in the year 2000.[2/]

The problems afflicting the health care system are national problems requiring national solutions. The business of health care in the United States is a

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[1/] Piacentini & Foley, EBRI DATABOOK on Employee Benefits at 215 (2d Ed. 1992) ("EBRI DATABOOK").

[2/] EBRI DATABOOK at 188, 194.

national industry serving a national marketplace that is immersed in, and has a major impact on, interstate commerce.

State borders are largely irrelevant to the provision of health care in the United States. Much of the nation's health care is provided by major hospitals and medical centers, health maintenance organizations, practice groups, managed care networks, and other organizations that conduct business across state borders, serve markets that cross state borders, and that draw their personnel from multi-state regions. Other industries concerned with health care coverage are also largely interstate in nature.

Similarly, a great many of the public and private health plans that finance health care coverage are interstate plans. Well over 80 percent of the nation's population is covered by a private or government health plan.[3/]

Many of the nation's employer-sponsored health plans -- which benefit over 60 percent of the nation's population -- cover the employees of multi-state employers.[4/] The largest employers, whose plans cover the largest numbers of employees, are <u>overwhelmingly</u> multi-state employers. As mentioned earlier, <u>all</u> of ERIC's members -- whose health plans cover ten percent of the nation's population -- operate in more than one state and provide coverage to employees, retirees, and dependents residing in numerous states.

Similarly, the federal government -- which covers approximately nine million employees, dependents and annuitants under the Federal Employees Health Benefits Program (FEHBP) -- is a multi-state employer in its own right[5/] and, like Medicare, FEHBP has an impact on the cost and economics of private employer coverage.

The federal government's plans -- including Medicare, FEHBP, veterans hospitals and benefits and CHAMPUS, state and local government plans, non-profits, private-sector employer plans and other arrangements all have an impact on one another. When any of these programs makes major changes in coverage and cost, the other plans feel the impact on quality and cost.

A multi-state industry of this magnitude, which has such a profound effect on the economy and which provides critical services to such a high percentage of the nation's population, cannot be left to a patchwork quilt of state regulation.

<u>"BALKANIZATION" OF THE HEALTH CARE SYSTEM THROUGH STATE REGULATION WILL BE COSTLY, HARMFUL TO EMPLOYEES AND THEIR DEPENDENTS, AND DAMAGING TO THE NATION'S HEALTH CARE SYSTEM.</u>

The key to successful health care system reform is a national policy that fosters improved health care quality, efficiency, and effectiveness. By contrast, state regulation of health care plans will "Balkanize" the regulation of health care

[3/] EBRI DATABOOK at 218.

[4/] EBRI DATABOOK at 218.

[5/] EBRI DATABOOK at 288.

by subjecting health plans to regulation by the laws of more than 50 different jurisdictions.

Balkanization will increase the cost of health care, increase the cost of plan administration, and prevent employers from providing uniform benefits to their employees on a nationwide basis.

Our health care system is already plagued by enormous inconsistency in the quality, efficiency, and cost-effectiveness of health care. Legislation that encourages individual states to pursue separate courses of action will promote conflicts between states, and between state and federal governments, and exacerbate the problems that now exist by inviting the states to take as many as 50 different approaches to the regulation of health care.

Since the federal government already manages, provides or regulates a substantial portion of the health care system, compatibility of private and public elements of the health care system can be assured only by the development of a comprehensive national policy.

Inconsistent state regulation will add significantly to the already high cost of providing health care coverage. Rules that vary from state to state will greatly increase the complexity of administering a multi-state health plan and will make it either impossible or far more expensive for a plan to offer the same coverage to all covered employees and their dependents, regardless of where they reside.

Faced with an array of conflicting state regulations and additional cost increases, employers will be forced to recoup the additional costs elsewhere. Some will curtail benefits, reduce other compensation, or terminate health care coverage entirely; others will pass the costs on to employees in other ways -- for example, by increasing the contributions that employees must make in order to obtain health care.

Even if a limited number of states seek to regulate health plans, employees in all states are likely to suffer. The additional costs that the state laws impose will not be borne solely by the employees who reside in those states. A multi-state employer that is burdened by the additional costs imposed by conflicting state regulations is likely to pass those costs on to its workforce as a whole, without treating employees differently depending on where they reside.

If the health care system becomes Balkanized, many states are likely to engage in a very unhealthy competition with each other as they seek to revise their health care laws in order to attract or retain business in the state. Thus, businesses will be encouraged to leave one state for another where health care coverage or costs are lower for reasons that may have nothing to do with quality of care. Whatever the merits of such "bidding wars" in other contexts, this is no way to fashion a sensible health care policy.

Costs will be increased not only by the inconsistency of state legislation but also by the content of that legislation. For example, if ERISA preemption is waived, states will be free to subject self-insured health plans to "mandated benefit" legislation that now applies only to insured plans under state insurance

laws. There are now over 900 mandated benefit laws on the books.[6] These laws vary widely from state to state; many of the laws appear to be designed to protect certain groups of health care providers rather than the health of the citizens of the state.

Mandated benefit laws prevent employers from providing uniform benefits on a nationwide basis, force employers to provide (and employees to receive) benefits that they do not desire in lieu of the benefits they prefer, and increase the number of employers that cannot afford to sponsor health care plans for employees and their dependents.

For example legislation introduced in the 102nd Congress (S.3180) would have allowed each state to (1) impose taxes and other fees on employee benefit plans, (2) mandate a standard benefit package, (3) establish a common administrative procedure, an electronic claims processing procedure, a data collection mechanism, and a utilization review, quality assurance, and medical outcomes mechanism, and (4) implement a negotiated health care provider reimbursement rate system.

Under the bill, all of these requirements could vary from state to state, thereby entangling multi-state health plans in a costly, complex, and inefficient morass of conflicting state requirements.

Although S.3180 included a limited exception for self-insured plans, the exception failed to provide meaningful relief for multi-state employers. The exception applied only to the state's standard benefit package. The exception did not apply to any of the other state mandates that the bill allowed, all of which could vary from state to state. In addition, the exception applied only if a new federal commission determined that the employer's per-employee contribution met a specified standard with the state.

The unfortunate experience we all had under Section 89 of the Tax Reform Act of 1986, prior to its repeal, teaches us that such determinations are extraordinarily difficult to make. Moreover, given the thousands of self-insured plans in the nation, it is clearly impractical to saddle a federal agency with the task of making individual determinations for each self-insured plan.

ALTHOUGH STATE TAXATION OF EMPLOYEE BENEFIT PLANS MIGHT BE POLITICALLY EXPEDIENT, IT IS INEQUITABLE.

Many of the proposals to weaken ERISA preemption are designed to permit the states to finance health care reform by taxing health plans or passing on that financing through "sick taxes."

Taxing health plans in order to finance the cost of health care reform is highly inequitable. Employers that voluntarily provide health care coverage, and the employees who participate their employers' plans, already pay more than their fair share of the cost of health care. Employer-sponsored plans generally cover not only the employer's own employees, but also the employees' spouses, including employed spouses whose employers do not provide health care. In

[6] Blue Cross & Blue Shield Ass'n, Issue Review (Feb. 1992).

addition, employer-sponsored plans must bear health care costs that have been inflated as a result of cost-shifting from Medicare and Medicaid and the cost of uncompensated care.

It is therefore highly inequitable to target employer-sponsored plans as a revenue source to finance reform of the health care system, particularly when the tax on employer plans is intended to subsidize those employers that do not offer health care coverage. A tax on employer-sponsored plans punishes those who already bear a disproportionate share of the cost of providing health care. Sick taxes, moreover, are particularly inequitable since they tax people when they are most ill; a substantial portion of that tax will be passed on to employees in the form of higher co-pays and deductibles.

States appear to have targeted employer-sponsored plans as a revenue source, not because taxing health plans is equitable or appropriate, but because the states have not mustered the political will to finance health care reform through equitable, broad-based taxes. The states' unwillingness to finance health care reform through broad-based taxes does not justify imposing inequitable taxes on those who already bear a disproportionate share of the cost of health care.

The problems created by state taxes on health care are not limited to employers and employees within the borders of the taxing state. There inevitably will be disputes <u>between states</u> regarding the scope of a state's taxing power. Last year, for example, *The Wall Street Journal* reported that Minnesota sought to levy a two percent tax on hospital revenue in order to finance its new health-care system and to impose its new tax on out-of-state hospitals (including Canadian hospitals) that treat 20 or more Minnesotans a year. Not surprisingly, according to the *Journal*, Minnesota's attempt to tax out-of-state hospitals provoked "feverish protests" from neighboring states.[7]

This recent experience in Minnesota illustrates the potential for "Balkan" conflicts among states -- both conflicts between the regulatory and taxing authorities of various states and conflicts that stem from the ability of individuals and businesses to move from one state to another in response to differences between state health care systems. It is difficult to believe that a rational health care policy will emerge from these conflicts.

<u>ERISA DOES NOT PREVENT THE STATES FROM EXPANDING HEALTH CARE COVERAGE.</u>

The states <u>can</u> expand health care coverage without amending ERISA. The states <u>can</u> enact legislation that expands health care coverage, or access to coverage, or that raises revenue to finance the cost of health care, without amending ERISA. The states have a variety of measures at their disposal to solve these problems. ERISA merely prevents the states from taxing and regulating employer-sponsored plans: the plans that already provide coverage to employees and their dependents.

Thus, ERISA does not stand in the way of any state that wishes to deal with health care as it would deal with any other social welfare issue. The problem is

[7] *The Wall Street Journal* at p. 1 (Sept. 2, 1992).

the states' unwillingness to address health care coverage and access issues without interfering with one aspect of the health care system that actually works and provides health coverage to approximately 150 million citizens: employer-sponsored health plans.

WEAKENING ERISA PREEMPTION WILL CREATE NEW BARRIERS TO NATIONAL HEALTH CARE REFORM.

Proposals to weaken ERISA preemption and to encourage the states to regulate the health care system pose two significant dangers.

First, state legislation is likely to act as a smoke screen that diverts attention from the need for federal legislation that addresses the nation's health care problems on a uniform, nationwide basis. If Congress weakens ERISA preemption and allows the states to regulate health plans, attention will be deflected from the need for national reform, and the momentum for national health care reform that has been building in recent years will dissipate.

Second, once the states establish their own regulatory regimes -- and invest considerable time and effort in implementing them -- there is likely to be strong resistance to proposals for a federal regime that will supplant state regulation. New state laws, and the state agencies that administer them, will create new constituencies that will have vested interests in preserving the status quo and that will resist federal efforts to reform the health care system on a uniform nationwide basis.

Ceding to the states the authority to regulate the health care system is thus likely to postpone federal action for the foreseeable future. State legislation will become a part of the problem, not the solution.

STATE REGULATION IS NOT THE ONLY ALTERNATIVE. CONGRESS SHOULD NOT ABDICATE ITS RESPONSIBILITY.

Sponsors of proposals to weaken ERISA preemption have argued that state regulation is the only alternative to the alleged "gridlock" that prevents federal reform of the health care system. This is simply not correct.

We are gratified by the serious and thoughtful efforts by many members of Congress, including many members of this Subcommittee, and by the Administration to address the nation's health care problems. The fact that there is not yet a consensus on how to solve these problems reflects the difficulty and magnitude of the problems, not the existence of a "gridlock."

Progress is being made, however. The positions of various proponents of health care reform are coming closer together, and many now acknowledge the need for a uniform national framework. This is not the time for Congress to throw in the towel. Congress should not abdicate its responsibility to address the nation's health care problems. To the contrary, Congress should now be renewing, not abandoning, its efforts to reform the nation's health care system.

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STATEMENT OF CAROLYN O. MAGGIO, P.D., LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS

Mr. Chairman, members of the committee, my name is Carolyn O. Maggio. I am the Executive Director of Research & Development for the State of Louisiana's Department of Health and Hospitals which administers Medicaid of Louisiana. I would like to thank you for inviting me to participate as a witness regarding state health care reform initiatives. The efforts of states to reduce the number of uninsured individuals and control the rise in health care costs should help frame the issues to be considered by Congress in addressing national health care reform.

In Louisiana approximately 25% of the population has no health insurance, and 14% of the population receives their health care coverage under Medicaid. Since 1988 Louisiana has worked to expand Medicaid coverage and thereby reduce the number of residents without health care coverage. Through utilization of disproportionate share payments to the state's public hospital network, Louisiana has been able to expand health care services to uninsured residents and expand Medicaid coverage.

Through utilization of state general funds combined with disproportionate share funds, Louisiana has made the following health care investments:

- Average Medicaid enrollment growth for annual membership has increased from 4.42% to 7.31% representing a 65% increase in average enrollment growth. Average part-year Medicaid enrollment growth has increased from 7.74% to 9.28% representing a 20% increase in annual membership growth.

- In the first year following expansion from 64 Medicaid enrollment locations to over 800 locations statewide with simplified procedures, annual membership has increased by an additional 5% while part-year enrollment growth has increased by an additional 29%.

- Part-year Medicaid enrollment for the current state fiscal year is projected to approach one-million representing a 58% increase in coverage since the advent of disproportionate share payments. Part-year enrollees represent the working poor and middle income families experiencing catastrophic health expenses. This significant expansion of Medicaid represents fulfillment of the governments responsibility to all of its citizens in their time of need.

- Payments for services have been increased each year to enhance participation and provide competitive rates for health care services.

- Covered services have been expanded to enhance primary and preventive care (case management, mental health rehabilitation, technology dependent care, etc.)

- Early, Periodic Screening, Diagnosis and Treatment services have been enhanced to increase the utilization of preventive services.

- School based clinic programs have been established in targeted areas to increase access and utilization of health care services by teen-agers from low-income families.

- State Hospital out-patient clinics have been expanded to reduce the need for in-patient care.

- State Hospital in-patient care has been expanded to allow provision of secondary and tertiary care to low-income populations who have no insurance.

- Replacement of hospitals and equipment has allowed initial development of a managed care platform for expansion to the entire system over the next five years.

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- Grants to small rural hospitals have allowed restructuring services to provide acute and primary health care services to local communities and reduce the incidence of closures.

- Disproportionate share payments to private hospitals have increased access to hospital care for both Medicaid enrollees and indigent patients.

In 1992 the State Legislature established a Health Care Commission to review the health care issues and problems facing state residents and develop solutions to assure all residents would have access to affordable health care coverage. Following the commission's first year of work, Louisiana is continuing the process of developing and implementing its health care reform strategy which includes the following components:

- A public health insurance plan sponsored by the state which is available to residents with incomes below 250% of the federal poverty limit who do not qualify for any public or private coverage. Under this option the number of uninsured residents would be reduced by approximately 10%.

- Amending current health insurance plan requirements to:

  - Raise the attaining age for dependent's health insurance coverage to 21;

  - Prohibit pre-existing condition exclusions for individuals who have no gap in coverage for a period longer than 90 days with total benefits paid carried forward to the receiving plan for application against any lifetime benefit limit;

  - Require utilization of modified community rating in setting premium rates;

- Prohibit insurers from canceling health and accident insurance policies on the basis of health experience or other contingencies of the insured through age 65; and

- Extend a former employee's ability to retain health insurance coverage through continued payment of premiums for up to 18 months.

- Adopting the following measures to reduce the cost of health care services:

  - Establishment of billing audit guidelines for insurance plans to verify the accuracy of hospital charges;

  - Establishment of standardized claim and filing standards for all health care providers;

  - Restricting physician self-referral practices.

- Piloting 24-hour medical coverage projects;

- Extension of the state's health care commission through 1995; and

- Establishment of a Health Insuring Organization in the Department of Health and Hospitals which would utilize competing health care plans to generate savings sufficient to allow expansion of Medicaid to cover all optional groups under the federal statute. The HIO would allow Medicaid to expand to 25% coverage of the state population and in conjunction with the public insurance plan reduce the number of uninsured to approximately 4%.

The approach being developed by Louisiana will guarantee the availability of health care coverage to all residents over a four to five year phase-in period. However, the approach taken does not guarantee

coverage of all residents. Those individuals who refuse to participate in public or private plans will remain uninsured.

The majority of provisions of the Louisiana plan have been adopted by the state legislature and forwarded to the Governor for approval. Because of the current debate on capping entitlement programs by Congress as well as other changes to the Medicaid program now pending in the Senate, the state legislature did not approve any expansion of Medicaid to additional low-income populations. Rather, the focus in Louisiana has now split with health care reform being considered for private coverage issues and reduction of coverage and services being considered for public programs. Changes in disproportionate share payments approved the U.S. House of Representatives could have a disastrous impact on Louisiana's efforts to expand health care coverage to low-income populations. As a result, national reform initiatives for low-income populations may be hampered by both public reaction to a "see-saw" approach of contraction and expansion of services as well as legislative support for any proposal which contains matching fund requirements or maintenance of effort provisions.

Louisiana has made no attempt to overtly control or limit the growth in private health care spending. However, the changes developed to increase accountability, streamline operations and guarantee access to basic health care coverage will allow market competition to control the cost of health care. The Louisiana Health Insuring Organization utilizes the same market driven techniques which are being considered for utilization in the national reform initiative being developed by President Clinton. An overview of this model is attached for the Committee's review ***(Attachment)***.

As Congress considers health care reform and continues its deliberations on reducing the national deficit serious consideration should be given to avoiding changes in existing health care programs in advance of any reform initiative. For over two years the states have been building support for health care reforms which would assure the

availability of health care services to all residents. National reform should be built upon the initiatives started by the states. Actions to reduce the federal deficit in advance of national reform which target health care services will require increased taxes at the state level combined with increasing the number of uninsured individuals and reducing the scope of medical services available to low-income populations. Such action will increase the cost and reduce support for any subsequent national health care reform initiative.

A Conceptual Approach To Improving Health Care Access In Louisiana

March 12, 1993

RESEARCH & DEVELOPMENT

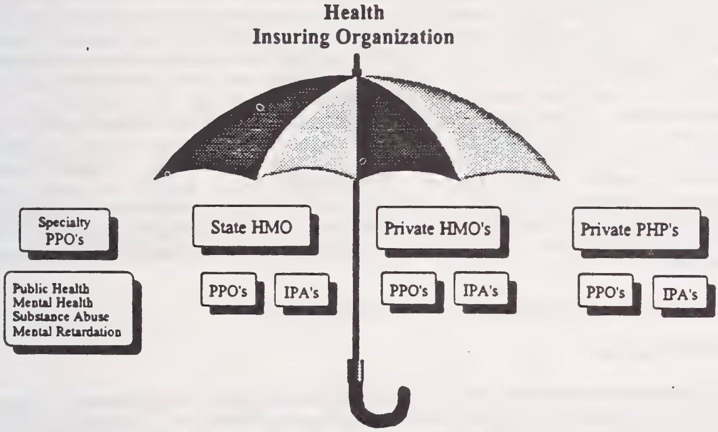
DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE OF THE SECRETARY
BUREAU OF RESEARCH & DEVELOPMENT

Executive Summary

➢ Of the 900,000 uninsured Louisiana residents, approximately 300,000 - 500,000 could be covered directly by Medicaid at a cost of $608 million ($438M federal & $170M state for 360,000 active users of health care services).

➢ Utilizing the federal option of providing health care services under a state owned Health Insuring Organization will allow combining care management and competition i.e. managed competition, in advance of federal reform legislation to generate the savings needed to finance Medicaid expansion.

➢ Structuring the Health Insuring Organization as a Health Care Umbrella for competing health care management plans will facilitate expansion of managed care plans in urban areas and development of a rural market. Through initial use of voluntary enrollment, the transition from fee for service to managed competition will be driven by market forces and fueled by the financial incentives available to health care management plans.



➢ As plan capacity increases transition from fee for service to managed competition can be facilitated utilizing a freedom of choice waiver which will allow Medicaid enrollees a choice of competing health care plans.

➢ Through transition from fee for service and expansion of Medicaid coverage to optional groups, competing health management plans are provided with a potential market of over 1,000,000 enrollees while the net cost of providing health care is reduced by approximately $60 million dollars per year.

The Louisiana HIO Proposal--A mini-model of the Clinton Plan

The Louisiana HIO proposal reflects the fundamental health care reform strategies of the Clinton plan for cost containment and expanded access. In addition, due to the state's long tradition of providing health care to the uninsured, restructuring the state health care network into an accountable health plan will assure continued viability of the teaching hospital and clinic system under national health care reform. This proposal allows the state to continue its strong tradition of providing health care to all its citizens; retains and enhances the state's major investment in the state charity hospital system and medical education programs; provides for full participation by federal facilities; and maximizes cost containment. The proposal can be viewed as the ideal "bridge" between the existing system and the national program under development.

The President's Concept: **Establish Health Budget Targets Through a Centralized National Board**

Louisiana's Proposal:

The health budget target would be effectively established by capitation of Medicaid and utilization of competition among health care management plans to maximize potential savings. This would be accomplished by development of a state-operated Health Insuring Organization (HIO) which would set capitated rates for managed care programs and link individual plan growth to financial stability and profit sharing. Savings achieved by improved primary care, resulting in fewer high-cost services such as hospitalization will act financial incentives for participating plans. Restructuring public facilities into a statewide HMO will maximize market penetration and provide a mini-umbrella for linking federal facilities and programs such as VA hospitals and Federally Qualified Health Centers. Restructuring public health care block grant programs into specialty service organizations will allow full coordination of specialty services and elimination of service duplication. The health budget target would, in effect, be the baseline cost following full transition of Medicaid and block grant programs.

The President's Concept: **Expand Access to Health Care**

Louisiana's Proposal:

The savings generated from the HIO capitated rate program would be used to expand Medicaid coverage to the fullest extent allowed under federal law. Louisiana currently covers approximately 600,000 citizens under Medicaid and the expansions could provide coverage for up to 500,000 additional persons with 360,000 active users of health care services.

As national health care reform expands health care coverage, the HIO will be capable of expansion or contraction to meet the needs of the residents of Louisiana.

The President's Concept: **Create Managed Competition**

Louisiana's Proposal:

Utilization of the HIO concept will provide the financial incentive for private insurance transition from indemnification models to health management models. By allowing market forces to react and drive expansion of health care management in the public sector, transition in the private sector will naturally follow. Conversion of basic indeminification models will result from changing dynamics in the health delivery system and provide the experience needed to assure provision of high quality care. The ability of health care management plans to expand into rural areas under the HIO will provide the financial incentives needed for growth and development of managed competition in the private sector with minimal disruption to businesses and industry.

The President's Concept: **Establish Health Networks**

Louisiana's Proposal:

The Louisiana proposal will maximize utilization of the state's unique public health care system. Services provided by the state's teaching hospitals and clinics will be networked with federally qualified health centers, rural health clinics, small rural hospitals and participating federal facilities to assure the availability of health care throughout the state. Federal block grant health care programs (public health, mental health, substance abuse, developmental disabilities, blind and deaf services), will be networked into a cohesive system to coordinate service delivery and fulfill their missions in their specialty areas, with central management oversight by the HIO.

The President's Concept: **Improve Community Prevention and Primary Care**

Louisiana's Proposal:

The state public health care system would be improved and re-oriented to track immunizations and screenings for all participating plan members and simplify the delivery of specialized services to women, infants and children.

Expanding Access To Medical Treatment Through Health Care Management

INTRODUCTION

Under federal statutes and regulations which govern the administration of Medicaid, states are provided with options designed to encourage the implementation of health care management initiatives and participation of health care management plans. The Louisiana Department of Health and Hospitals (DHH) proposes to utilize one of the more successful types of health care management, authorized under federal regulations, referred to as a Health Insuring Organization (HIO). Under this approach, the state would establish an HIO within the DHH to act as an administrative umbrella for increasing the availability of competing health care management plans such as Health Management Organizations (HMO's), Prepaid Health care Plans (PHP's), Preferred Provider Organizations (PPO's), and Independent Practitioner Associations (IPA's). Through competition and marketing of health plans to the Medicaid population, access to health care services would be increased while providing a strong financial incentive for expansion of the managed care market throughout the state. Savings resulting from provision of health care through managed competition model will not only reduce the cost of providing health care coverage but facilitate expansion of Medicaid to optional groups of uninsured residents.

In conjunction with establishing a Health Insuring Organization, the Department will also establish a state owned and operated Health Maintenance Organization composed of the state's teaching clinics and hospitals. Through subcontracting arrangements the HMO will be able to serve participating members in rural areas of the state and develop a public primary health care network composed of public and private programs and organizations. Through revitalization of the existing public facility infrastructure in the state and networking with existing underutilized facilities, the State's teaching hospital and clinic system will have the opportunity to once again be recognized nationally as a medical training model.

Under the HIO umbrella specialized health care services traditionally administered under federal block grant programs will be utilized to coordinate specialty care for all plan members and thereby eliminate waste and duplication of effort in the delivery of services. The following features of the proposed state HIO are designed to assure financial solvency and stability of the state's health care system.

- Through establishment of a state owned and operated HIO, traditional public sector services provided by the Louisiana Health Care Authority and DHH can be integrated while assured continued financing and utilization.

- Establishing capitated rates[1] for Medicaid on a risk basis and restricting capitation to the state operated HIO assures all competitive health care plans are administered by a single

[1] Rates are set based on the average cost of providing specific health care services as determined under an actuarially sound methodology approved by the federal government.

entity to assure quality and uniformity in service standards and rates. The federal government is guaranteed to pay no more than the current average Medicaid cost for health care services provided under the health care management program, and savings resultant from operation of the HIO are utilized for expansion of health care coverage and reduction of the cost of providing health care under Medicaid.

- Medicaid eligibility will be guaranteed for a six month period for any enrollee who chooses to receive services under the HIO as allowed under federal regulations. Through guaranteed eligibility, neither the state nor the health plans operating under the state's HIO umbrella will be exposed to any risk resulting from retroactive Medicaid ineligibility based on changes in enrollee income or resources during a certification period. Without this option, the state would be exposed to paying the full cost of health care services provided to enrollees whenever Medicaid determined eligibility should have ended based on changes which were not timely reported. Additionally, under this option, marketing of health care plans to Medicaid enrollees is enhanced through reduced bureaucratic requirements, increase access to primary and specialized care, and guaranteed coverage for a six month period.

- Utilizing waiver of 75/25 participation requirements[2] for the state HIO will expand the number of health care management plans available to Medicaid enrollees. Through increased availability of health care management plans, the percentage of Medicaid enrollees choosing to receive services under the HIO umbrella will increase.

- Utilizing 100% capitation, updated quarterly for new enrollees, reduces the state's exposure to cost overruns. Plans operating under the HIO umbrella will be offered premium payments on a risk or shared risk basis. To the extent the HIO assumes a part of the plans risk of potential losses, the HIO will require a greater share of any profits generated by the plan. These two options will be structured to assure the solvency of the HIO and encourage health care plans to participate.

- Establishing Medicare premium amounts for the HIO will allow health care management plans to market themselves to Medicare enrollees as well as Medicaid enrollees under the HIO umbrella. This feature will allow individuals who have dual coverage for Medicare and Medicaid to join a participating health care management plan.

- Establishing coordination and referral arrangements between participating health care management plans and the public service delivery system will assure continuing compliance with federal requirements, increased access to specialized services, and risk management for competing health care plans.

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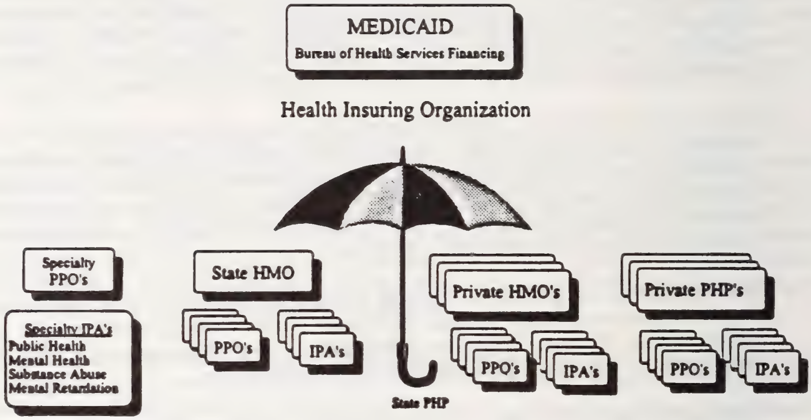
[2] Federally qualified HIO and PPO plans which are operated by states may serve low-income populations exclusively. Private HIO and HMO plans are required to meet a 75/25 minimum public/private participation rate to retain federal approval.

The HIO will improve access through availability of health care services from new and existing health management plans which will reduce utilization of Emergency Rooms for primary health care, long distance transportation, and the incidence of in-patient hospitalization. Savings generated by the HIO will facilitate expansion of Medicaid coverage. Utilizing this approach, the growth of health care management plans should increase significantly during the first year of operation. Sufficient enrollment and resultant savings are projected to allow phasing-in additional optional Medicaid coverage groups during the first year of HIO operation.

This approach will maximize federal funding for health care services in Louisiana, provide the financing needed to expand Medicaid coverage to over 360,000 uninsured residents under a health care management model which is compatible with health care reform proposals being considered by Congress, and provide a basis for private health care plans to evaluate and develop competitive health care plans for the private sector.

HIO ORGANIZATION

The following diagram illustrates how the state's HIO model provides for administration of competing health plans.



Multiple health care plans will market themselves to Medicaid enrollees under the HIO umbrella. The HIO will establish a uniform marketing protocol with Medicaid and coordinate plan member marketing efforts. Health Maintenance Organizations (HMO) and Prepaid Health care Plans (PHP) will be required to coordinate and administer a benefit package and allowed to include any of the following optional benefits:

MINIMUM BENEFIT PACKAGE	OPTIONAL BENEFITS
Hospitalization - Inpatient & Outpatient	Dental & Denture services
Laboratory & X-Ray services	Clinic Pharmacy services
Physician services	Rehabilitation services
Other practitioner services	Nursing Facility services
Home Health services	
Durable Medical Equipment services	
Transportation services	

Preferred Provider Organizations (PPO) and Independent Practitioner Associations (IPA) will be allowed to enroll in conjunction with HMO's and PHP's[3] for provision of any of the above listed services except hospitalization. The state PHP will administer and coordinate the following specialty services for all health care plans.

Public Health services
Mental Health services
Psychiatric Hospital services
Substance Abuse services
Mental Retardation/Developmentally Disabled services

Specialty PPO's operating under the state PHP will coordinate and report to participating HMO's and PHP's, those services provided to plan members to assure: continuing compliance with federal requirements; reduced risk of plan cost overruns; and reduced duplication of effort.

State Prepaid Health Care Plan

The HIO umbrella will provide basic benefits through multiple competing plans and specialized health care services for Medicaid enrollees with special needs. The state PHP will administer and coordinate all specialized health care services for participating plans. Through administration and coordination of specialized services by agencies with established state wide networks the special needs of local populations can be accommodated. Participation in designing and delivering specialized health care services by local communities and organizations is maintained through use of existing public agencies and integration of private sector service delivery systems. Additionally, compliance with various federal mandates regarding the provision of specialized health care services is assured through administration by the agencies charged with responsibility for compliance.

State Health Maintenance Organization (HMO)

The state will establish a federally qualified public HMO to compete under the HIO umbrella utilizing state owned and operated clinics and hospitals. To assure statewide access the state HMO will contract with Federally Qualified Health Centers, Rural Health Clinics, rural hospitals and any federal facilities who have excess capacity and wish to participate in the health care network. Through revitalization of the existing public facility

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[3] The state Prepaid Health-Care Plan (PHP) will be available to all PPO's, IPA's, etc. to assure participation in the HIO is not artificially limited.

infrastructure in the state and networking with existing underutilized facilities, the State's teaching hospital and clinic system will have the opportunity to once again be recognized nationally as a medical training model. The regional structure of the Health Care Authority will facilitate decentralization of service administration and flexibility in designing services to meet the special needs of each geographic region of the state as well as fully utilizing publicly funded health care resources.

ENROLLMENT PERIODS

Medicaid enrollees choosing to receive services under the HIO umbrella will be guaranteed continuous eligibility for a six month period. Movement between plans will be restricted to prevent unnecessary paperwork and administrative costs. Medicaid enrollees will be free to change plans every six months or earlier for cause. During the first 30 days of coverage under any HIO participating health care plan, the Medicaid enrollee shall have the option of cancelling membership in the HIO and returning to Medicaid.

ADDITIONAL INFORMATION

Additional information regarding Louisiana's Health Insuring Organization may be received by contacting:

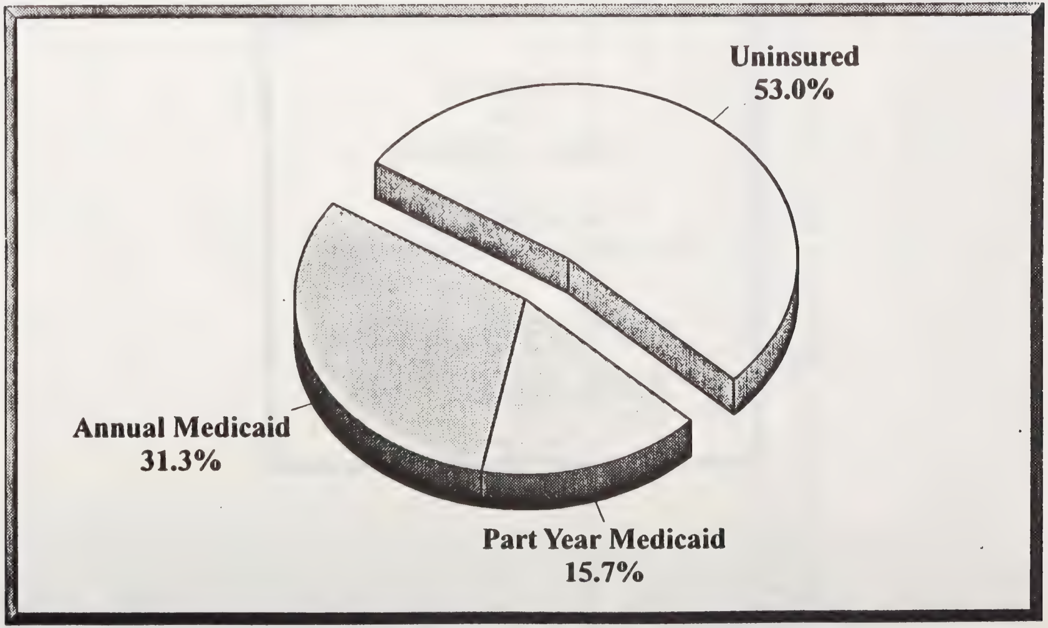
Louisiana Department of Health and Hospitals
Bureau of Research & Development
Post Office Box 2870
Baton Rouge, Louisiana 70821-2870

HEALTH CARE MANAGEMENT

A CONCEPTUAL APPROACH TO IMPROVING

ACCESS, CHOICE & QUALITY

CURRENT MEDICAID & UNINSURED LOUISIANA RESIDENTS



MEDICAID OPTIONAL COVERAGE GROUPS

PREGNANT TEENAGERS LIVING WITH PARENTS - 5,368 Potential Enrollees
(Medicaid currently provides coverage for pregnant teenagers in families with incomes below 33% of federal poverty level)

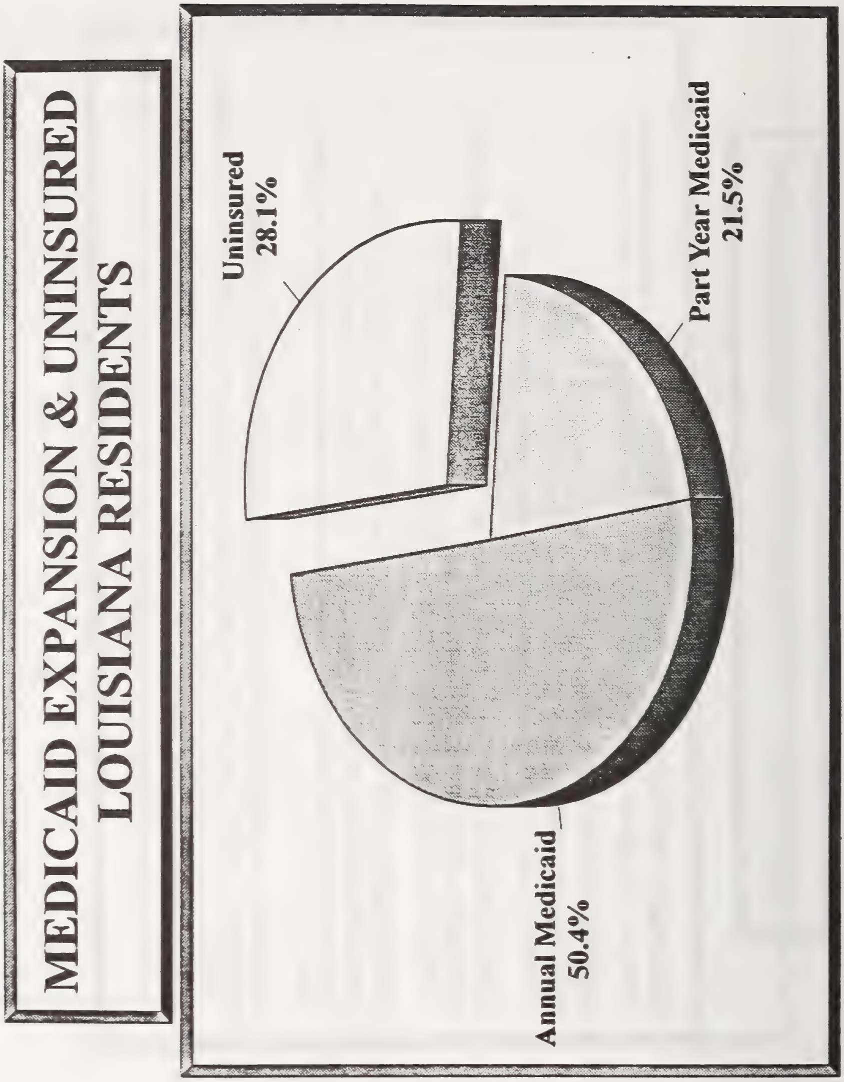
PREGNANT WOMEN WITH INCOMES BELOW 185% OF THE FEDERAL POVERTY LEVEL - 20,406 Potential Enrollees
(Medicaid currently provides coverage for pregnant women with incomes below 133% of federal poverty limit.)

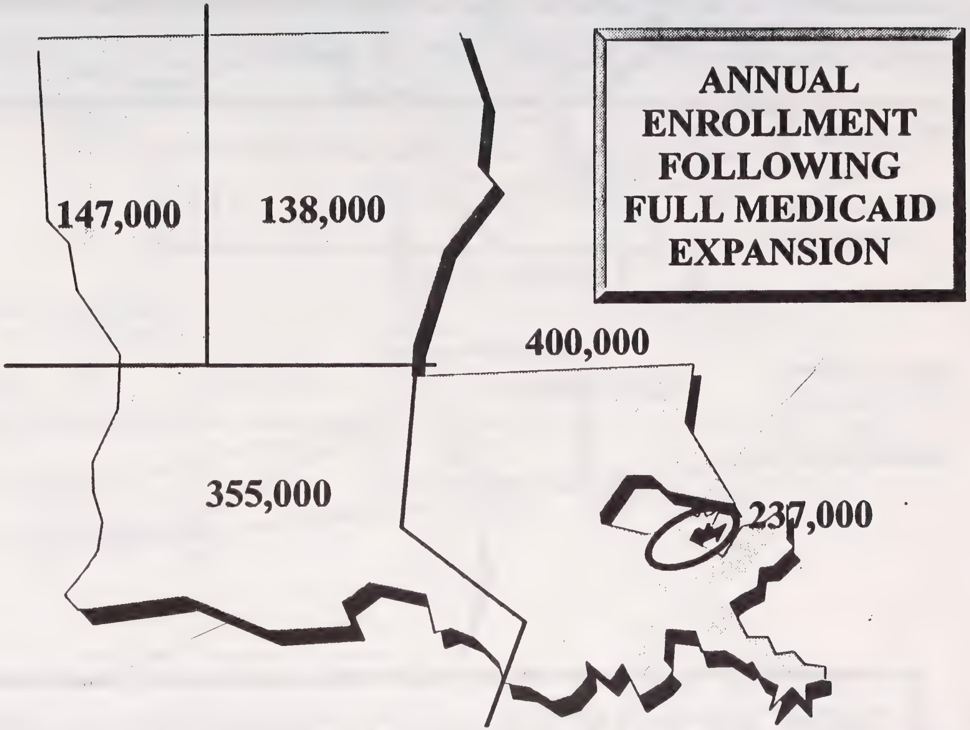
DEVELOPMENTALLY DISABLED CHILDREN WHO WOULD BE COVERED BY MEDICAID IF INSTITUTIONALIZED. - 2,500 Potential Enrollees
(Medicaid currently covers institutionalized children and children who have been institutionalized.)

AGED, BLIND, & DISABLED INDIVIDUALS WITH INCOMES BELOW 100% OF FEDERAL POVERTY LEVEL - 90,343 Potential Enrollees
(Medicaid currently provides coverage for institutionalized individuals and individuals with income below 50% of federal poverty level.)

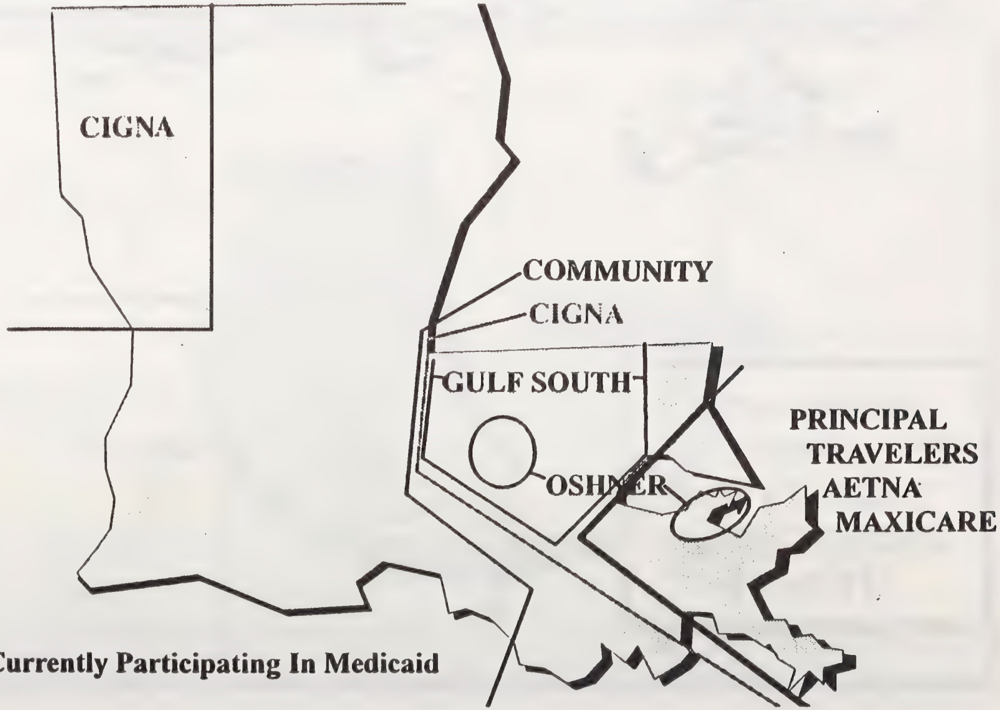
CHILDREN IN FAMILIES WITH INCOME BELOW 100% OF FEDERAL POVERTY LEVEL AND ONE PARENT OR GUARDIAN - 350,295 Potential Enrollees
(Medicaid currently provides coverage to families with incomes below 30% of federal poverty level.)

TOTAL = 468,912 POTENTIAL ENROLLEES


MEDICAID EXPANSION & UNINSURED
LOUISIANA RESIDENTS
Uninsured
28.1%
Part Year Medicaid
21.5%
Annual Medicaid
50.4%

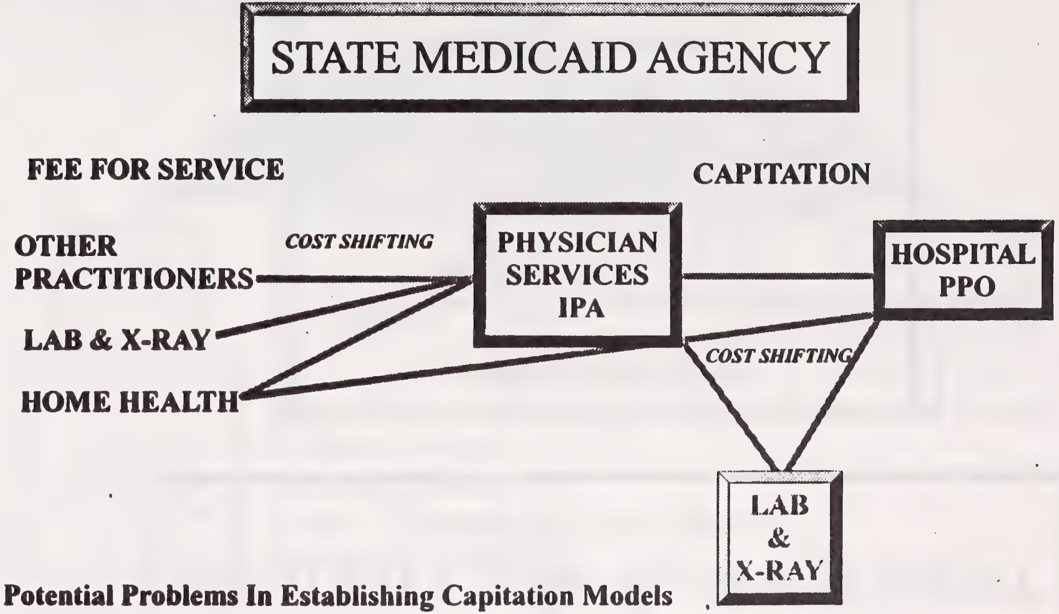

ANNUAL
ENROLLMENT
FOLLOWING
FULL MEDICAID
EXPANSION
147,000
138,000
400,000
355,000
237,000

PRIVATE HMO COVERAGE PLANS



* None Currently Participating In Medicaid

PARTIAL CAPITATION OF SELECTED SERVICES



Potential Problems In Establishing Capitation Models

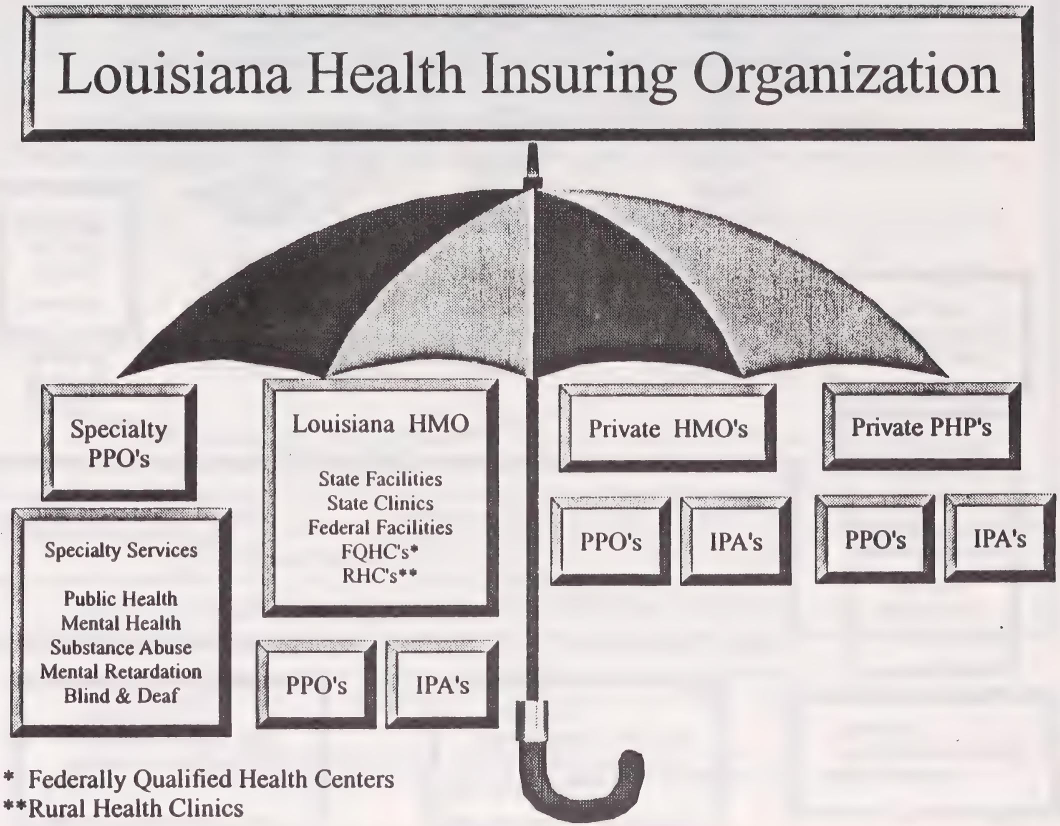
HEALTH CARE MANAGEMENT
BENEFIT PACKAGE

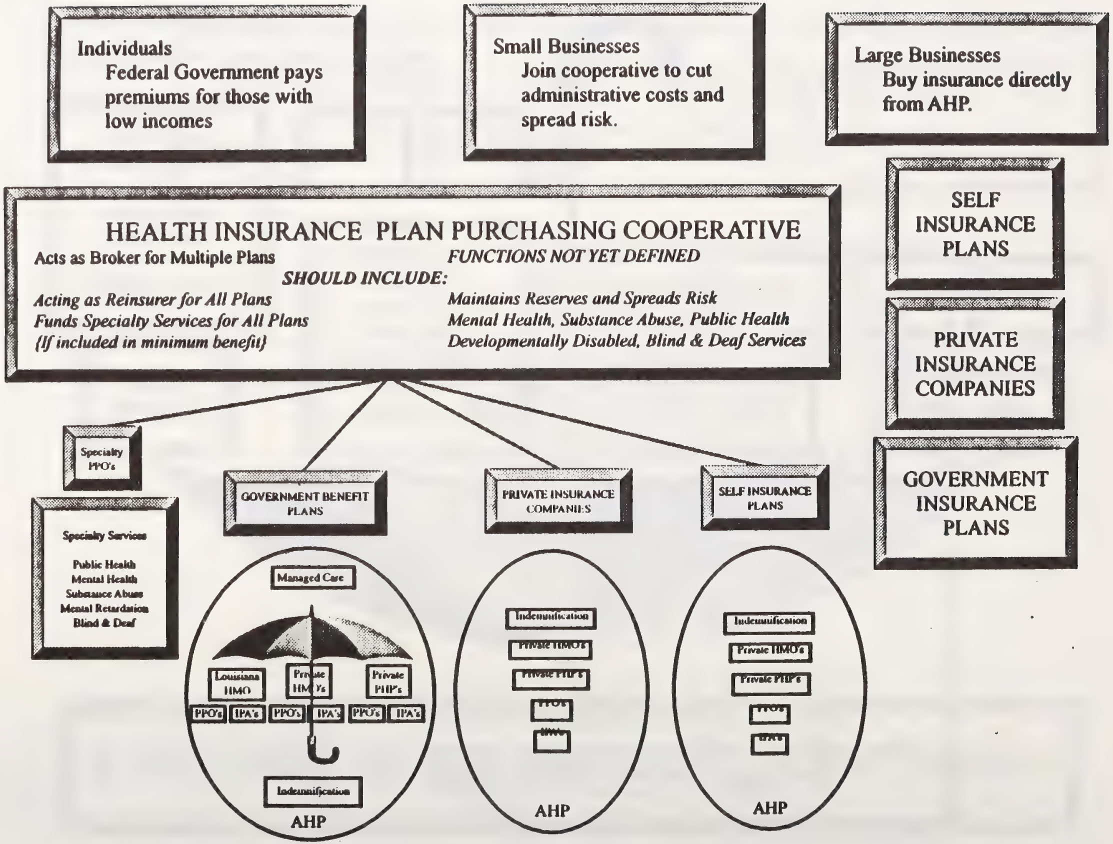
MINIMUM SERVICES:

HOSPITALIZATION - Inpatient & Outpatient
LABORATORY & X-RAY
PHYSICIAN SERVICES
OTHER PRACTITIONER SERVICES
HOME HEALTH SERVICES
DURABLE MEDICAL EQUIPMENT
TRANSPORTATION SERVICES

OPTIONAL SERVICES:

DENTAL & DENTURE SERVICES
CLINIC PHARMACY SERVICES
REHABILITATION SERVICES
NURSING FACILITY SERVICES


Louisiana Health Insuring Organization
Specialty PPO's
Specialty Services
Public Health
Mental Health
Substance Abuse
Mental Retardation
Blind & Deaf
Louisiana HMO
State Facilities
State Clinics
Federal Facilities
FQHC's*
RHC's**
PPO's
IPA's
Private HMO's
PPO's
IPA's
Private PHP's
PPO's
IPA's
* Federally Qualified Health Centers
**Rural Health Clinics



Individuals
Federal Government pays premiums for those with low incomes
Small Businesses
Join cooperative to cut administrative costs and spread risk.
Large Businesses
Buy insurance directly from AHP.
HEALTH INSURANCE PLAN PURCHASING COOPERATIVE
Acts as Broker for Multiple Plans
FUNCTIONS NOT YET DEFINED
SHOULD INCLUDE:
Acting as Reinsurer for All Plans
Funds Specialty Services for All Plans
(If included in minimum benefit)
Maintains Reserves and Spreads Risk
Mental Health, Substance Abuse, Public Health
Developmentally Disabled, Blind & Deaf Services
SELF INSURANCE PLANS
PRIVATE INSURANCE COMPANIES
GOVERNMENT INSURANCE PLANS
Specialty PPO's
Specialty Services
Public Health
Mental Health
Substance Abuse
Mental Retardation
Blind & Deaf
GOVERNMENT BENEFIT PLANS
PRIVATE INSURANCE COMPANIES
SELF INSURANCE PLANS
Managed Care
Louisiana HMO
Private PHP's
PPO's
IPA's
Indemnification
AHP
Indemnification
AHP
Indemnification
Private HMO's
Private PHP's
AHP

MEDICAID OF LOUISIANA

Capitation Limited to a Single State Health Care Management Agency.

Actuarial Sound Capitation Methodology Based On Medicaid Enrollment
(Category of Assistance, Age, Sex, and Zip Code Incorporated To Prevent Adverse Risk Selection)

Profits from Risk Based Capitation Restricted To Financing Health Care For Uninsured.
For Groups Not Subject to Mandatory Participation Capitation Set at 100%.
For Groups Mandated to Participate Capitation Set at 95%.

Sharing of Risk and Profits Following Expansion of Medicaid to Cover All Optional Groups.
Capitation Adjusted To Reflect Profit and Risk Experience.

Medicaid State Plan Amended To Provide Six Month Coverage Guarantee
Health Care Management Enrollees Are Guaranteed Fixed Coverage Period.
Minimum 30 Day Orientation Period Prior To Beginning Coverage.
Following Selection Of A Management Plan, Notification To Plan Is Provided To Schedule Orientation.
Free Movement Between Plans During Orientation Period.
Free Movement Between Plans Every Six Months.
Restricted Movement Between Plans During Coverage Periods.

LOUISIANA HEALTH INSURING ORGANIZATION

Oversees Administration of Multiple Plans and Acts as Broker

Louisiana Health Insuring Organization

Establishes Uniform Benefit Package
Establishes Plan Participation Requirements
Enrolls Plans Based on Membership and Capacity
Establishes Quality and Economy Drivers
Sets Premiums for Participating Plans
Audits Plan Costs and Evaluates Quality

State Prepaid Health Care Plan

Federal Block Grant Programs Provide Specialty Services for All Plans

Mental Health
Substance Abuse
Public Health
Developmental Disabilities
Blind & Deaf Services

State Health Maintenance Organization -

Utilizes State and Federal Facilities in conjunction with Federally Qualified Health Centers and Rural Health Clinics to form a Public Health Care Network

Provides for participation by underutilized hospitals as well as PPO's and IPA's .

Private HMO's
Private PHP's

Private plans are allowed to enroll and offer the basic benefits package to Medicaid enrollees. Plan economy and quality standards are utilized to prevent over saturation of plans in any geographic area of the state.

Services may be provided through arrangements with PPO's and IPA's.

STATE PREPAID HEALTH-CARE PLAN

Specialty Services for All Plans

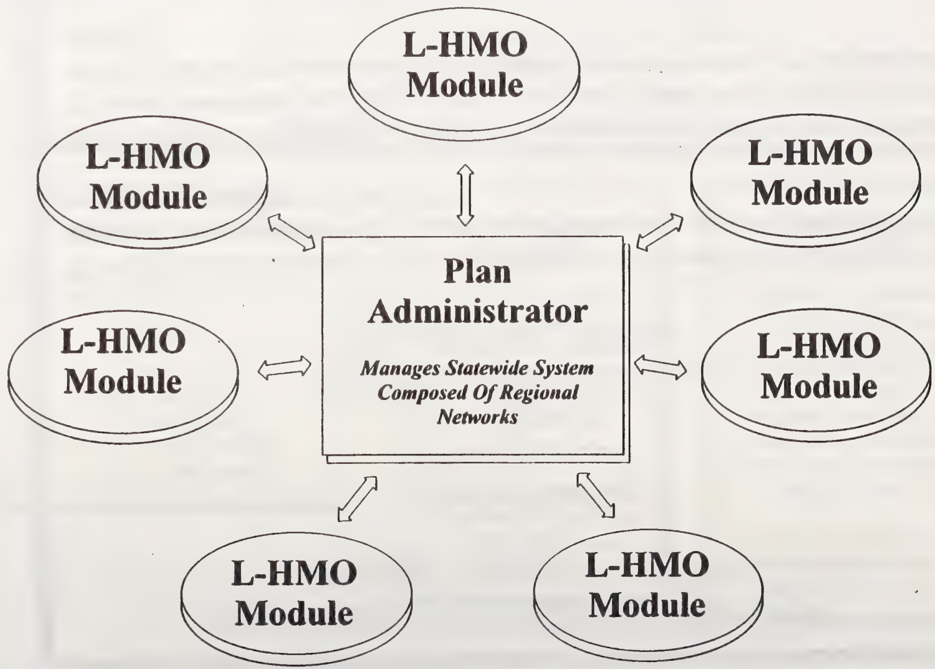
Mental Health
Substance Abuse
Public Health
Developmental Disabilities
Blind & Deaf Services

Through administration and coordination of specialized services by agencies with established state wide networks, the special needs of local populations can be accommodated.

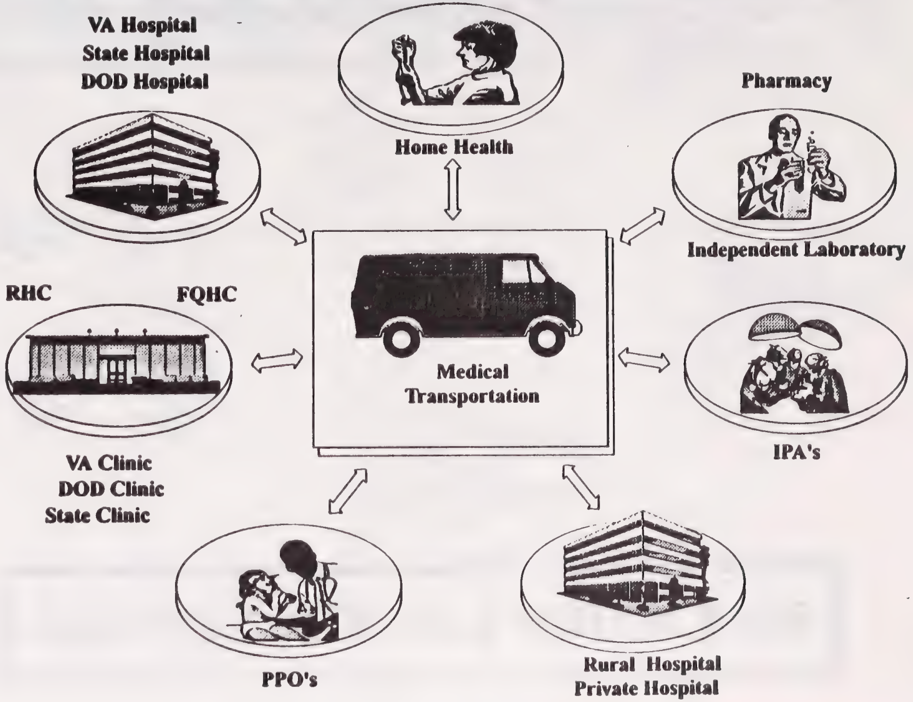
Participation in designing and delivering specialized health care services by local communities and organizations is maintained through use of existing public agencies and integration of private sector service delivery systems.

Compliance with various federal mandates regarding the provision of specialized health care services is assured through administration by the agencies charged with responsibility for compliance.

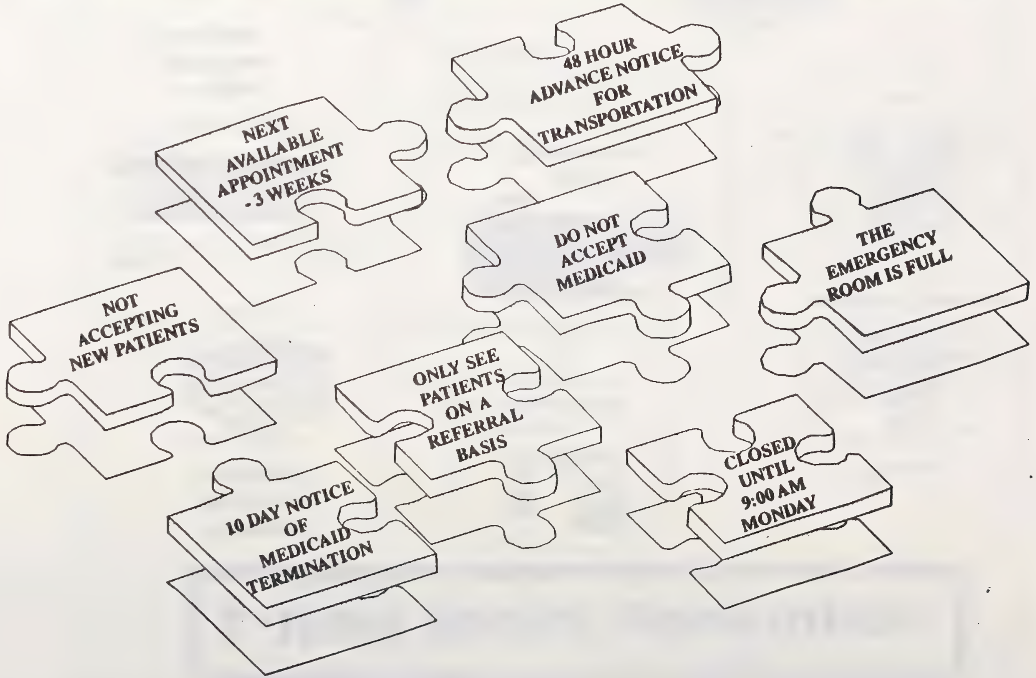
State Health Maintenance Organization

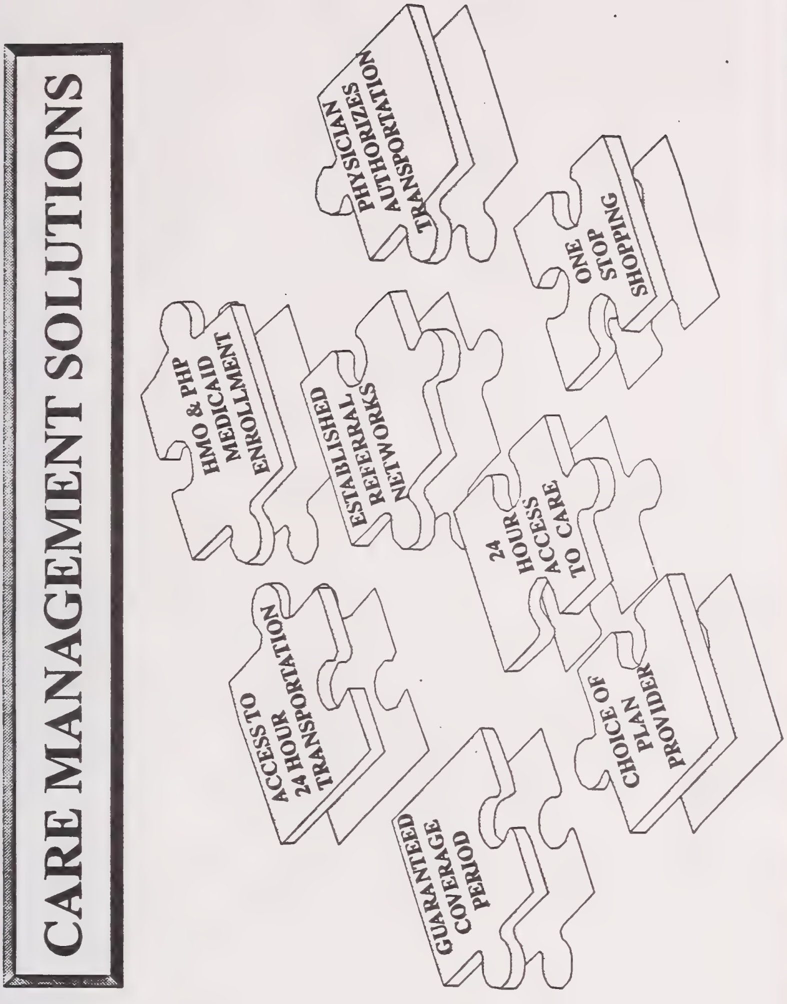


L-HMO Module Administrator



FEE FOR SERVICE PROBLEMS

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